			-	ertificate o	Health and M f Death	1	Reg. No.	04. 3	25001
	Dhusisian	Decedent's Name (First, Middle, Last)				2. Dete of De Month	eth Day	Year	3. Time of Death
	Physician /Medical	Howard Lee Cook, Jr.				August 6		1	2:25 A.M.
	Examiner	4a Fecility Neme (If not institution, give street end number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death	
	S.	Manor Care-Bethesda			Bethesda		Montgo		
	Funeral Director	1MM 2□ E	(In yrs. last birthda 71 Yrs	Months Dev		8. Date of Bird (Month, De Oct. 14	h y, Year) 1932	9. Birthplace Country) New Yo	e (State or Foreign ork
	9	Usuel Residence of Decedent							60 1: 0
	ahow ed at		10c. City, Town or						Inside City Limits
	vith the Meryle or 28a-f sho be notified at Director	Maryland Montgomery	Bethesd	la					1 ☐ Yes 2 🗖 No
	t to or 2	10e. Street end Number		10f. Zip Code			10g. Citizen of V	Vhat Country	?
	th will	9517 Linden Avenue		20814			United	States	
	fier deeth v	11. Meritel Status 12. Was Decedent Ev Armed Forces?	ver in U,S. 1	3. Was Decedent of	Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No	14. Rac	e - American k, White, etc	
Maryland 21215-0020	by by	1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 3 ☐ Widowed 4 ☒ Divorced Year or Dates:		1 ☐ Yes 2 💢 N		riboni diony	i	White	
Ö	ed within 72 hor ygiene. ner than "natura nt, the Medical Int.	15. Decedent's Education	16e. De	cedent's Usuel Occ	upation		16b. Kind of Bu	usiness/Indus	try
3	ole no no	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)	(G life	e. DO NOT use reti	e during most of work red)	ing			
7	Jene.	5+		bbyist			Self E	mploye	d
D		17. Fether's Neme (First, Middle, Last)		•	18. Mother's Nam	e (First, Middle,	Maiden Sumam	ne)	
<u>a</u>	Mentel Mentel arked o artic eve	Howard Lee Cook, Sr.			Helen L	onice V	ັດນາກ <i>ຕ</i>		
<u> </u>	d 2 should be filed the and Mentel Hygn Is marked othe traumatic event,	19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Address (Stre	et end Number or Rur			State, Zip Co	ode)
₹	d 2 s	Laura Cook Holmes/Daughter			Avenue, Be				
	es 1 and 2 should be of Heelth and Mentel I Item 27 is marked o r other traumatic ever	20a. Method of Disposition	20b. Place of Di	sposition (Name of		Date	20c. Location -		
Baltimore,	nit. Peges ertment of I ortant: If ite Injury or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Parklaw Pa	rematory or other p in Memoria ark		ug. 10, 2004	Rockvil:	le, Ma	ryland
Ball	permit. Peges Depertment of Important: If I any Injury or pncs.	21. Signature of Funeral Service Licensee	M01353	22.Name and Add Bethesda- Bethesda,	tress of Facility Rob Chevy Chas Maryland	ert A. e, Inc. 20814-3	Pumphre 7557 W: 3501	y Fune iscons	ral Home/ in Avenue
		23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line			•			i In	pproximate terval Between nset and Death
9	Physician Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Myocardi	ial Infa	rction				1	
		0	ue to (or as a con						
	Pa st of	Diabetes	s Mellit	us					
	ficete be executed 3 physician end ss the bunel-trensit edical Examiner	Sequentially list conditions,	ue to (or as a con	sequence of):				1	
68760,	o cian	Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury	Artery 1	Disease					
87	ficete be physicia ss the bur edical	that initiated events resulting in death) Last	ue to (or as a con						
	W	Hyperten	sion						
Box	ettending for use e	d. 31							
	deed deed deed deed deed deed deed dee	Part II. Other significant conditions contributing to death but	not resulting in th	e underlying cause	given in Part I.	23b. Did	tobacco use co	ntribute to th	ne cause of death?
P.0	thet the deeth certi ted by the ettending detached for use c V Physician/M	Coronary Bypass Graft 1996				10	Yes 2□ No	3 Probal	bly 4X Unknown
ś	igned be de								
Sord	w require	History of Angioplasty thre	ee times			24a. Was	an autopsy ormed?	availa	autopsy findings able prior to oletion of cause
Division of Vital Records,	yysician: The law requir nis certificate hes been si I director, page 2 should To Be Completed	History of Respiratory Failu	ure, Atr	ial Fibri	llation	10	Yes 2 🗓 No		res 2□ No
/ita	entific ector.	25. Was case referred to medical			26. Place of Dea	th (Check only	one)		
=	hysic his ce	1 ☐ Yes 2X No Hospital: 1 ☐ Inpatien	t 2 ER/Outpa	Illent 3L DOA	41		idence 6 □Oth		
0	Affer the funerel		Year) 28b. Tim		ijury at Vork?	28d. Describe	how injury occur	rred	
<u>.</u>	ath. r: Af ne fu	2 Accident investigation			☐ Yes 2 ☐ No				
<u>\$</u>	Atte	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, farm	, street, factory, office	ce ce	28f. Location	Street and Numi	ber or Rural F	loute Number,
	tal or Attending P rs efter death. al Director: After t led in by the funer Certification:	Sulding, etc.	(Specify)			0.0, 0. 10	,,		
	To the Hospital or Attending Physician: The law requires thet the death certi within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be detached for use Medical Certification: To Be Completed by Physician/M		examination end/o	eath occurred at the or investigation, in m	time, date and place, y opinion, death occur	, end due to the rred at the time,	cause(s) and m date and place,	anner as stat and due to th	ed. ne cause(s)
	ithin of the sample	29b. Signature and title of certifier/	71	29c. Lice	ense number		29d. Date signe	ed (Month, De	y, Yeer)
N. Comments	F 3 F 8	1 Wist: Voh	NO /	7. D 20	274		A	2007	
							August 6	, 2002	<i>t</i>
	9	30. Name end address of person who completed cause of de- Kirti Vohra, M.D. 7710 Brad1	Let Blvd.		da, Maryla	nd 2081	7		
	State Registrar	31. Date filed (Month, Day, Yeer) 32. Registre	r's Signature	B 4	rocks				

DHMH 16 Rev 6/95

		•	For State Registrar			d / Depa		lealth and	Mental Hyg	•	0.	E000
			1. Decedent's Name (First, Middle, Las	it)					2. Date of Deat	h U U		3. Time of Death
	hysicia/ Medic/		MARY	Dea	x1				August	Day Y	er 204	3:56 PM
	Examin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, Town, o	r Location of Dea	th	4c. County of	Death	
			GIICHRIST				Tows			Bal	timo	ce
	ineral rector		207-05-1781	9X	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		^{Year)} 30,1918	Birthplac Country PF	ce (State or Foreign)
CICIS-UUSO filled within 72 hours after death with the Maryland Hygiene.	f show	tor	Usuel Residence of Decedent 10a. State 10b. County MD Balti	mara		Town or Lo	ocation				10d	. Inside City Limits
the	1 28e	lrec	10e. Street and Number		1 100	3011	10f. Zip Code		1	0g. Citizen of Wha	at Country	1?
h with	39 o	Funeral Director	302 E. Joppa Road	i Apt. 1	1211		21286	i		United 9	State	!S
deat	E LE	ner	11. Marital Status	12. Was Decede	ent Ever in U.S	13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race -	American	Indian,
ours after	el', or ite Examina	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 Tes 2 If Yes, Give Year or Date	Ľ X No		1 ☐ Yes 2 💢 No	Specify:	to Alcan, etc.)	Specify:	White, etc	White
od within 72 hours aff gjene.	ortent: If tiem 27 is marked other then "neturel", or Items 23e or 28e-f show injury or other treumatic event, the Medical Examinar must be notified at 8.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed) College (1-4	lor 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	orking	16b. Kind of Busin	ness/Indus	stry
d wit	t a	No.	, , , , , , , , , , , , , , , , , , , ,		2	Un	derwriter			Mortgage	e Com	pany
2 should be filed within and Mental Hygiene.	vent	Be (17. Father's Name (First, Middle, Last)						me (First, Middle, I	Maiden Sumame)		
id 2 should be file th and Mental Hy	rked tic e	10	Rhys E. Carter					Elizat	oeth Owe	ns		
2 should and Men	8 mg		19a. Informant's Name/Relationship (7	Гурө, Print)		19b. Mailin	ng Address (Street	and Number or A	ural Route Number	, City or Town, Sta	te, Zip C	ode)
1 and 2 Health	n 27 l er tre		Robert Deal/son			9 Tig	erwood Co	urt Par	kville, k	MD 212:	34	
as 1 se of He	r oth		20a. Method of Disposition 1 Durial 2 Ocremation 3 D	D		ace of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location - Cit	y or Town	n, State
Pages nent of h	iry o		`4 □ Donation 5 □ Other (Specify		ate	-	Svc. Corp		06/2004	Towson.	Mary	land
permit. Pages 1 a Department of Hea	Importe any inju once.		21. Signature of Funeral Service Light	see S.		22	2. Name and Addre	ss of Facility Ru	uck Towson Towson, Ma	n Funeral	L Hom	ne, Inc.
3	Su.		23a. Partl. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final								A	pproximate iterval Between Inset and Death
/Me	sician edical miner		disease or condition resulting in death)		as a consequ	ence of):					1	o days
cuted	d ansit	Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jisaas or ki, ir) that initiated events	b. Due to (or	as a consequ	ence of):						
ate be executed	physician and s the burial-transit	cal	resulting in death) Last	Due to (or	as a consequ	ence of):						
OI VILAI NECOLUS, F.O. DOX OS Physicien: The law requires that the death certifica	been signed by the attending ph should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 Fetal nt at time of de	death 3[Ectopic pregnancy Other (specify)	/		23d. Date of Month	-	ay Year
he law requires that	n signed l	by	Part II. Other significant conditions of Heart Fa	ontributing to dea	th but not resu	lting in the u	nderlying cause giv	en in Part I.		oacco use contribu es 2 V rto 3		cause of death? ly 4 □Unknowr
		Completed	Arry Junia						24a. Was a	n 24b. We	re autops	y findings available
ne la	age 2	E C	Gastrointe	1 0	W1.	. 1			autops	ned? dea	th?	letion of cause of
Physicien: T	or, p		25. Was case referred to medical	tinace	Ble	ed		26 Place of Do	1 ☐ Yes :	-	Yes 2	☐ No
/s C	s cert	o Be	eyaminer?	Hospital:	patient 2 E	B/Outnaties	t 3C DOA Oth	O.C.	Home 5 Reside		(Specify)	Hospico
	After this certificate has funeral director, page 2	\vdash	27. Manner of Death	28a. Date of (Month,		28b. Time o	f 28c. Injur	y at	7	ow injury occurred	(Зр о спу)	Hoshic
th ding	: Afte	tlo	1 SNatural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	Wor M 1 □	k? Yes 2 ∐No				
l or Attending after death.	Director: I in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Place of	f Injury - At hor , etc. (Specily)	ne, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number n, State)	or Rural F	Route Number,
To the Hospitel or A within 24 hours after	To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the b niner: On the bas and manne	is of examinati	vledge, deat on and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	e, and due to the courred at the time, d	ause(s) and mann ate and place, and	er as state I due to th	ed. ne cause(s)
To th within	To th	Me	29b. Signature and title of certifier	V			29c. Licens			9d. Date signed (i		
	1			1			D 00	57740		Aug.	8.2	004
	6		30. Name and address of person who	ey, Mp	. 8	501	Las Mle	Ks 9	ife loz-	Towson	MA	21286
	Sta Registr		31. Date filed (Month Day Year) 2	004 32. Reg	istrar's Signati		1					

William Dickerson Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a, 27 per MR C835, 9/9/04 TT State of Maryland Department of Health and Mental Hygiene 04-05086 MES 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** William E. Dickerson pM 4:42 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, June 24, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 238-92-9657 1**∑**M 2□ F 48 Yrs. Troy, Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai", or items 23a or 28e-f show Examiner must be notified at NC Lincoln Lincolnton 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2223 Lake Street 28092 USA Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑☑0 If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1XXNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dick Dickerson Betty Gaddy ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Teresa Bruton / Sister 902 East Main Street, Candor NC 27229 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marcus UMC Cemetery Aug 8, 2004 1 ☐ Burial 2 ☐ Cremation 3 XRemoval from State permit. Page Department of Importent: If any injury or once. Candor, NC * 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility} Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service LicenseeVictor P. Doda, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Hypertensive Atherosclerotic Cardiocvascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any least sequentially cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the Hospitel or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 DEctopic pregnancy in the past 12 months? Year Day Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? page Yes 2 No Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Yes 2 ☐ No ۵ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident the Director 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signafare and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 32. Registrar's Signature

32. Registrar's Signature

OCME

August 7, 2004

AUG 0 9 2004

31. Date filed (Month, Day, Year)

Uhne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James is force

ORIGINAL

		State of Maryland / Department			ental Hygie	ne	
		Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of	Death	Reg.	No.	7 5 11 0 L
Physicia	ın	Charles E. Fields			Month	Day Year	2 ol nu
/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	Location of Death	August	3 2000 4c. County of Dea	7
Examin	EI	Sinai Hosmital	Bal	timore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Bir	thplace (State or Foreign ountry)
Director		216-07-3457			Oct. 8,	1912 Mai	ryland
land	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ocation				10d. Inside City Limits
Mary -f she	to	Maryland N/A Baltimor	P				1 X Yes 2 □ No
th the or 28s	Director	10e. Street and Number	10f. Zip Code		10g	. Citizen of What C	ountry?
23a c		224 W. Rogers Avenue	21209)		U.S.A.	
er des	Funeral	Armed Forces?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
rs aft	by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give Year or Dates:	1⊡Yes 2⊠ No	Specify:		Specify: Wh:	ite
be filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be notified at		15. Decedent's Education 16a. Dece	dent's Usual Occup		16	b. Kind of Business	
thin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired	during most of worki d)			
ed wi ygien rer th	Co	8th Grade Cler	:k			ewspaper	
ntal H	Be	17. Father's Name (First, Middle, Last) Elmer Fields		18. Mother's Name Susie l	(First, Middle, Ma. Embrey	iden Sumame)	
2 should and Men is marke	ြ		ng Address (Street	and Number or Rura		ity or Town State	Zin Code)
od 2 s Ith an 27 is i traum			-	s Avenue			21209
s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Dispo	osition (Name of matory or other place	cal	ate 20	c. Location - City or	r Town, State
Pages nent of i			of Faith		/04 0	verlea, M	[aryland
permit. Pages 1 and 2 should be filed within Department of Health and Mantal Hygiene. Important: If item 27 is marked other than eny injury or other traumatic event, the Magnes.		21. Signatura Funeral Service Licensee	2. Name and Addre	ss of Facility	ral Home.	Inc.	
20.500	-	23a. Parti. Enter the disease, or complications that caused the death. Do not ent	o415 Bela	ir Road l	Baltimore	, MD 212	206 Approximate
		shock, or heart tailure. List only one cause on each line.	ter the mode of dyir	ng, such as cardiac d	or respiratory arrest	*	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)					1243
Examiner		Due to (or as a consequence of):					
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
cate be executed physician and sthe burial-transit	Examiner	that initiated events c.					
be exectan stantal	E	resulting in death) Last Due to (or as a consequence of):					
physicate s the l	edicai	d					
The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of de	elivery
death death e atte	Physician/M	in the past 12 months? 1 Vas 2 No. 1 Pregnant at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify)</i> _	у		Month	Day Year
that the deby the	hys	9 Unknown					
res tha igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the u	ınderlying cause gıv	en in Part I.			to the cause of death?
w require been sig should b	ted	Augsenson			1 L Yes	2 □ No 3 □ P	
e taw has b	Completed	Dewerta.			24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of
n: Th licate r, pag					1□ Yes 2€	ZNo 1 ☐ Ye	s 2111No
sicial s certi irecto	э Ве	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatien	nt 3□ DOA Ott	ner	(Check only one)	se 6 □Other (Spe	
g Phy er this	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of			28d. Describe how		өспу)
ath. r: Afte	atio	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation		Yes 2□No			
r Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Stre- City or Town,	et and Number or F State)	Rural Route Number,
ral Di							
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, deal (Check only one) 1 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the tinvestigation, in my o	me, date and place, opinion, death occurr	and due to the cau ed at the time, date	se(s) and manner a a and place, and du	as stated. Le to the cause(s)
To the Within To the	Me	29b. Signature and title of certifier	29c. Licens	se number	290	. Date signed (Mon	nth, Day, Year)
		rang Willin	D	00217	30	8 30	4
m		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Ho 8	00217 B	al time	2 .	
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	1			
Registr	ar	AUG 0 9 2004 General 19	ports				

DHMH 17 Rev 1/2001

A. Known as Morles Fields

			1 - For Registrar	State of Marylar			t of Health and e	_	0.0.0.1	00000
			Registrar 1. Decedent's Name (First, Middle, La	et)	Cei	lilicate	e or Death	2. Date of De	Reg. No.	3. Time of Death
	Physici	an	EthelreDA		lbeck			Month	Day Year	4/6 A M
1	/Medic		4a. Facility Name (If not institution, giv		VECK		Town, or Location of Deat	Magus	4. County of Deal	
	Examin	er		OFAL			Baltimore		4c. County of Deal	ırı
-	Funeral		5. Social Security Number 6.5		last birthday)		1 Year If Under 24 Hrs		rth 9. Bird	thplace (State or Foreign
М	Director		213-09-5202	1 M 2 N F	/ / Yrs.	Months	Days Hours Min.	Month, Da	ay, Year) Co	ARY/PND
			Usuel Residence of Decedent					TO TO TO TO	2, 1,201 19	77777
	how Let		10a. State 10b. County		ty, Town or Lo	-				10d. Inside City Limits
	Se-4	ct ct	MARYLAND	13	Altire	ore				1 ☐ Yes 2 ☐ No
	11 th	Dire	10e. Street and Number			10f. Zip			10g. Citizen of What Co	
	72 hours after death with the Marylend naturel; or items 23a or 28e-f show Jical Evar, it ar must be motified at	Funeral Director	7/3 south C	onkling Str			21224		U.5 A	
	er de	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Deced If Yes, spec	lent of Hispanic Origin? (S ofy Cuban, Mexican, Puer	specify Yes or No to Rican, etc.)	0- 14. Race - Ame Black, Whit	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📆 No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Specify:		Specify: /	Uhite
21215-0036	hour	pe p	15. Decedent's E		16a Decer	dont's Heus	al Occupation		16b. Kind of Business	
5	in 72 in a	Siet	(Specify only highest gra	ade completed)	(Give	kind of wor DO NOT us	rk done during most of wo se retired)	rking	160, Kind of Business	andustry
12	within lene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			corn		Hoschill	d- Kohn
	Hygid other	BeC	17. Father's Name (First, Middle, Last)	1			me (First, Middle	, Maiden Sumame)	
Maryland	lid be fental rked (To B	FRANCIS	Ko	DERM	CR	For,	WA	7.	Smith
ar _y	shound N	-	19a. Informant's Name/Relationship ((Street and Number or Ru		er, City or Town, State, a	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylen f Heelth and Mental Hygiene 1 f Heelth and Mental Hygiene 1 fem 27 is marked other than "natural", or items 23s or 28e-f show other treumatic event. I'm Medical Evacilier mast he notified at		JAMES A. Gold	dheck - DON	713	5. 6	ONKling 5	Street	Balto 4	1021224
Baltimore,	of He of He r other		20a. Method of Disposition	20b. F	Place of Dispo cemetery, crer	sition (Nan	ne of ther place)	Date	20c. Location - City or	Town, State
Ē	permit. Peges Depertment of I Importent: If it any injury or o		1, Surial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif	JRemoval from State (b)	IV Red	ee.me.	o Comiltuo	7 2001	BAltIMOR	U Manulano
a E	mit. pertra porte y inju		21. Signature of Funeral Service Lice	nsee	7 22	. Name an	d Address of Facility N Z ANN	To	Funcase 1	Lone /
Ö	Depermination of the series of		> (Oparl V	Lourens		63 c	South Conki	vo St. BA	Hr Manulon	10 21224
			23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal	th. Do not ent	er the mod	e of dying, such as cardia	or respiratory a	urrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	/						Onset and Death
	/Medical		disease or condition resulting in death)	a. ASDICATIO Due to (or as a consec	nuencelof):	kum.	7 1/a			
	Examiner	Ì		2 1	25+ruc					
	_ ~	Der	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec		1701)				
	cuted nd ransli	Examiner	that initiated events	C						
oʻ	en er	EX	resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	cate be executed physicien end i the burial-transit	dicai		d						
	ntifica ing pl	Med	IF FEMALE:							
Вох	that the death certificed by the ettending predetached for use as	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	ancy aldeath 3□	Ectopic pr	egnancy		23d. Date of del	
o.	e des the ett	sic	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of of 9☐ Unknown	death 5 □	Other (sp	ecity)		Month	Day Year
<u>P</u>	d by I	Phy	9 Unknown					00. 014		
Ś,	es light		Part II. Other significant conditions of	contributing to death but not res	sutting in the u	nderlying ci	ause given in Part I.		tobacco use contribute to	
of Vital Records,	v requir	Completed						10	Yes 2 No 3 Pr	obably 4 🖯 Unknown
e C	las b	npie						24a. Was auto	psy 24b. Were au	topsy findings available completion of cause of
=	The date he	Sol						perfo	ormed? death? 2 No 1 Yes	
/ita	ding Physician: Th h. After this certificate funeral director, peg	Be	25. Was case referred to medical examiner?					ath (Check only o	one)	
=	hysi his c	ဥ	1 ☐ Yes 2 ☑ No		ER/Outpatien			lome 5□ Resi	idence 6 □Other (Spe	cify)
		ë.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?	28d. Describe	how injury occurred	
sio	Attending r death. Sctor: After by the fune	cati	2 Accident investigatio 3 Suicide 6 Could not b	10		М	1 ☐ Yes 2 ☐ No			
=	2 4 4 5	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str fy)	eet, factory	, office	28f. Location (City or To	'Street and Number or Ru wn, State)	ural Route Number,
ני	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		One Continue							
	Hos 24 ho Fun fely f	lica	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of my knominer: On the basis of examina	owledge, death ation and/or in	n occurred a vestigation,	at the time, date and place in my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29b. Signature and title of certifier	and manner stated.			License number		29d. Date signed (Mont.	
	F 3 F 8		Offit	To M. D.		230	017-17-		N	IL 2 F.A.IL
•			- CO GAC	a 110			11164.2	4	The ugust	TEUT
O			30. Name and address of person who	completed cause of death (Iter		Print)	1 21 10 =	R11-	INEREM	Y 2 - 2
	Sta	to	31. Date filed (Month, Day, Yeer)	32. Registrar's Signa		1 17 1	- 11:16	UTIL	INIONE P	124122
	Registr		AUG 0 9 2004	Server	6 1	DOLL	21			

			State of Maryland / Department of Health an Certificate of Death	d Mental Hy	giene	04	25006
	-		Decedent's Name (First, Middle, Last)	2. Date of Di	eath		3. Time of Death
	Physicia		Edith Heilbrunn Glavan	August	6, Day	004 Year	2:47A M
•	. /Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D			unty of Death	1
			Shady Grove Adventist Hospital Rockville		Mon	tgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Bi	rth ay, Year)	9. Birth	nplace (State or Foreign
١.	Director		051–12–7696 1 Yrs. 91 Yrs.			12 Geri	
	* 4		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		· ·		10d. Inside City Limits
100	fsho	5	Maryland Montgomery Rockville				1 ☐ Yes 21 No
4	28e-	Director	10e. Street and Number 10f. Zip Code		10g. Citizer	n of What Cou	untry?
	3a or		15305 H Diamond Cove Terrace 20850		Unite	d Stat	AS
1	ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	? (Specify Yes or N		Race - Amer	ican Indian,
5	or Ite	Ē	Armed Forces? If Yes, specify Cuban, Mexican, P 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify:	'uerto Hican, etc.)		Black, White	e, etc.
3	End',	d by	3 ☑ Widowed 4 □ Divorced Year or Dates:		Sp	ecify: W]	hite
	Interventions are beautiving the waryar at the White waryar at the Hygiene. Ad other than "natural", or fears 23a or 28e-f show event, the Medical Examiner must be notified at event.	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind	of Business/I	ndustry
	ne. han	m Id	Elementary/Secondary (0-12) College (1-4or 5+)		771		
1	Hygie ther t nt, to		2 Floral Designer 17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Middle		rist	
	ntal B	Be.	V	ietta Fra		,	
•	permit. Pages I and 2 should be filled within Department of Harlb and Medial Hygiene. Important: If Item 27 I marked other than any injury or other treumatic event, I a Medial Mose.	မှ	19b. Mailing Address (Street and Number of				in Code)
	Ith ar 1th ar 27 la r treu		Frances Emily Glavan/Daughter 15305 H Diamond Cove		-		
ָר נ <u>י</u>	Hea Heam Item		20a Method of Disposition 20b. Place of Disposition (Name of	Date		tion - City or T	
2	ont of		Metiopolitan	gust 7, N4	Alex	andria	۲7.Λ
	ortar inju		21. Signature of Fineral Service Licensee 22. Name and Address of Facility	Robert A.	Pumph	rev Fu	neral Home/
בֿ בֿ	D D E D E		M00803 Rockville, Inc.	300 West	0°2805	mery A	venue
	N THE		23a. Part1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition necrotizing fasciitis				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence ::				54.75
٠	Examiner		Sequentially list conditions.				
3	sit a	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
_	and I-tran	хап	resulting in death) Last Due to (or as a consequence of):				
	cate be executed physician and the burial-transit	alE					
	phys the	edical	d				
<	attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d	I. Date of deliv	very
ָ וֹ	dean d for	icia	in the past 12 months? 1			Month	Day Year
)	ed by the detached	hys	9 ☐ Unknown				
ń	signed l	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
5	been si should	O		_ 1 🗆	Yes 215	6 3 ☐ Pro	obably 4 Unknown
נ נ	as be	Complete		24a. Wa	s an 2	4b. Were aut	topsy findings available ompletion of cause of
	rne ate h page	Con		perl 1 ☐ Yes	ormed? 2/20No	death? 1 ☐ Yes	25 %
1	aicien: The law s certificate has b irector, page 2 s	Be	eyaminer?	Death (Check only			
5	this c	P		ng Home 5 Res			eify)
	After funera	lon	27. Manner of Death Natural 5 Pending (Month, Day Year) Natural 5 Nestigation Pending (Month, Day Year) Natural 5 Nestigation M 1 Yes 2 No	28d. Describe	now injury o	ccurrea	
מ	deatl ctor: y the	ficat	2 Accident	-	(Street and N	lumber or Ru	ral Route Number,
	after Dire	Certification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State)		
i	spita nours neral		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	place, and due to the	e cause(s) an	d manner as	stated.
	To the hospital or Attending Pryaiden. The law requires that the death certific within 24 hours after deep of the most of the formal of the function of the fu	edical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death one)	occurred at the time	, date and pla	ace, and due	to the cause(s)
	To t	Σ	29b. Signature and title of certifier 29c. License number		29d. Date s	igned (Month	n, Day, Year)
			> Aliera J. Mistry MD D59738		mugi	usr 6	, 2007
9		100	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia T. Mistry 9901 Medical center Dr	rive Ro	ckuil	le, m	D 20850
	Sta Registi		29b. Signature and title of certifier Pluce J. Mustry MD D59739 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alicia T. Mistry 9901 Medical contex Dr 31. Date filed (Month, Day, Year) AUG 0 9 2004 32. Registrar's Signature AUG 0 9 2004				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 8:30 P. Hazel P. Humphries July 17, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Nursing and Rehabilitation Center Montgomery Kensington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 □ F 272-05-0462 Director September 9,1912 Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f show treumatic event, the Madical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Kensington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 3000 McComas Avenue 20895 United States or Items 23a death v Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 Never Married 2 Married 1 Tes, Give 20 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "r any injury or other treumatic event, it a Mad 2008. Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk 12 0 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John J. Pfadt Rosalee Sawyers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2009 North 14th Street #306 Arlington, VA 22201 Charles Cate/ Gaurdian 20b. Place of Disposition (Name of cometery, crematory or other place)
Geo. Wash. University 20c. Location - City or Town, State 20a. Method of Disposition July 17 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 2004 Medical Center 22. Name and Address of Facilit Columbia Mortuary Services, Inc. 21. Signature of Funeral Service Licensee P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Due to (or as a consequence of) Examiner certificate be executed as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 Unknown 1 Tyes 2210 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other ၉ 1 Tes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending Is within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eld 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

PHILIP C. HANSON 04-05091 RKD

	1 - For Amend & University Ragistrar	State of Maryland pend Item #1,23	1,27,28a-1 per Certificate of L	me G834 8/17/0 Death	Rag. No. 0 0 4	25009
Physician	Decedent's Name (First, Middle, La			2. Date of D Month	Day Year	3. Time of Death
/Medical	Philip 4a. Facility Name (If not institution, gir		Hanson 4b. City, Town, or I	AUGUS	T 5, 2004 4c. County of Deat	6:06P. "
Examiner	2703 N.CALVERT S		BALTIMOF		N/A	11
Funeral	5. Social Security Number 6.	Sex 7. Age (In yrs. la		If Under 24 Hrs. 8. Date of 8 (Month, D	irth 9. Birt	hplace (State or Foreig
Director	1/9-66-3402	1X M 2□F 23	Yrs. Worths Days		4, 1980 Ten	nessee
A ==	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limit
natural, or items 23a or 28a-f show iteal Evanitrat must be redified at etch by Funeral Director	Maryland N/A	Ba	altimore			1X Yes 2 □ N
e rodi	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
r Items 23a or 28a-f sl charmant be notified Funeral Director	2703 N. Calvert	Street	2121	8	U.S.A.	
tems ar m	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Specify Yes or N n, Mexican, Puerto Rican, etc.)	lo- 14. Race - Ame Black, White	
f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exactlear must be notified at To Be Completed by Funeral Director	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ XNo	Specify:	Specify: Wh	ite
ical E	15. Decedent's E		16a. Decedent's Usual Occupa (Give kind of work done do		16b. Kind of Business/	
ygiene. ner than "natur. it, the Medical.	(Specify only highest given Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)			
her that the the that the the that the that the that the the the the the the the the the th	12		<u>Waiter</u>	18. Mother's Name (First, Middl	Restaura	nt
ad oth	17. Father's Name (First, Middle, Las			•	•	
To Should by given in an and Mental Hygiene in a far and Mental Hygiene in a far and mental than "I raumatic event, the Mad To Be Comple	Gary Arnold 19a. Informant's Name/Relationship	Hanson (Type, Print)	19b. Mailing Address (Street a	Elizabeth S nd Number or Rural Route Num		Zip Code)
27 Is	Gary Arnold Hans	son Father	1541 State R	oute 18 Aliqui	ippa. Pa. 15	001
of Health Itam 27 I	20a. Method of Disposition	CO.	ace of Disposition (Name of metery, crematory or other place	Date	20c. Location - City or	
ury or	1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ify) Hill	top Service Co		Towson	Maryland
perim. rages of Department of Hisparams injury or ot once.	21. Sign sure of Funeral Service Lib	ensee	22. Name and Address	Mack Town	on Funeral	Home, Inc.
10 E e a	1 all the	tagan	1050 York			21204
	23a. Part1. Enter the disease, or conshock, or heart failure. List ont	y one dause on each line.	Do not enter the mode of dying	g, such as cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
hysician /Medical	Immediate Cause (Final disease or condition resulting in death)	Fentany1 In				
xaminer		Due to (or as a consequent	ance ot):			
ner	Sequentially list conditions, I any leading to in reduce cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consacu	ence of			
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hysician and the burial-transitie burial-transities and Ilcal Exami		Due to (or as a consequent	ance of):			
physic s the b	`	d				
gned by the attending phoe detached for use as the detached for use at the detached for the detac	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnan	icy		23d. Date of de	ivery
he atternation and for u	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de			Month	Day Year
by the tached	9 Unknown	9□ Unknown				
interiaw requires that the death behind to the has been signed by the attending page 2 should be detached for use as completed by Physician/Mec	Part II. Other significant conditions	contributing to death but not resu	iting in the underlying cause give		tobacco use contribute to	
been s should leted						obably 4 Unknov
te has been sage 2 should				24a. We	s an 24b. Were au prior to death?	itopsy findings availat completion of cause o 2 No
				1 又 Yes		2□ No
r this certificated director, ITO Be C	examiner?	Hospital:	ER/Outpations 3CI DOA Othe	26. Place of Death (Check only 4 □ Nursing Home 5 □ Re.		CCENTE
er this c seral dire	1 XYes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 3 DOA 28c. Injury Work	4 Nuising Home 5 Ne	how injury occurred	city) SCEINE
Attending r death. ector: After by the fune ification	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat		Found work		1	
rs after death. sal Director: After t led in by the funers Certification;	3 ☐ Suicide 6 【Could not determine	be 28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office		(Street an 2703° No	rth"Calver
ral Dire		Scene			3, Baltimore	
hospital 24 hours a Funeral I etely filled dical Ce	29a. Certifier 1 ☐ Certifying I (Check only 2 ☑ Medical Ex	Physician: To the best of my know aminer: On the basis of examinati				
± 4 m €	OHE)	and manner stated.	29c. License	number	29d. Date signed (Mont	h, Day, Year)
o the Fune o the Fune ompletely fil	29b. Signature and title of certifier		250. 11001138	Hulliber		
ed ple		withwill ner			AUGUST 6. 20	004
within 24 To the F Complete		WHMU, MD to completed cause of death (Item	0	.C.M.E.	AUGUST 6, 20	004
within 24 To the F Complete	29b. Signature and title of certifier	- /	O 23a) (Type, Print)			

	1	State of M State Amend Item 19b per Fi	aryland / Depa I,G834,08/ 0/	artment of Healt Model Incate of Dea	th and Me ath	ntal Hygi	ene g. No. O. O. I	00010
Dhysisian		. Decedent's Name (First, Middle, Last)				. Date of Death Month	Day Va	3. Time of Death
Physician /Medica	1	JEAN		HOFFMAN 4b. City, Town, or Locat		AUGUST	6, 2004	8:30 A
Examine	r ⁴	 Facility Name (If not institution, give street and number) 12109 REARDON LANE 		BOWIE			,	GEORGE'S
Funeral Director	5		ge (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8 urs Min.	Date of Birth Month, Day, OCT 12	, 1911 ^{9.}	Birthplace (State or Foreig Country) PA
show		Jsual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limi
1he M	Director	MD PRINCE GEORGE'S	ВС	OWIE 10f. Zip Code		10	og. Citizen of What	
3a or		12109 REARDON LANE		207	'1 5			USA
al', o	by rur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces 1 Yes 2 Wifyes 2 Wifyes Give Year or Dates:	? No	Was Decedent of Hispani ff Yes, specify Cuban, Me 1 ☐ Yes 2 ▼ No Spe	c Origin? (Speci xican, Puerto Ri ecity:	fy Yes or No- can, etc.)		American Indian, Vhite, etc. WHITE
within 72 ho ane. than "netur be wedical i	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or	(Give	dent's Usual Occupation kind of work done during DO NOT use retired) UNCHER	most of working	7	16b. Kind of Busine	·
Hygle Hygle ent.		17. Father's Name (First, Middle, Last)	INETT		Nother's Name (Maiden Sumame)	-
2 should be filed within and Mental Hyglene. Is marked other than eumatic event, the Mental Comments of the Mental	o Re	SAMUEL	AUST	IN	SARAH			PEARL
s 1 and 2 should f Health and Men item 27 ie marke other treumatic		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and N	Lane .			
ges 1 and 3 t of Health If item 27 or other tr	-	ROCHELLE ABRAMSON / DAUGH 20a, Method of Disposition	20b. Place of Dispo	osition (Name of	Da	-	MD 20715 20c. Location - City	
000		1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		matory or other place) T MEMORIAL F	ok 8/8/2	004	TREVOSE.	. PA
permit. Page Department Importent: It eny injury o once.		21. Signature of Funeral Service Licensee	2	2. Name and Address of F	acility SOL	LEVINSO	ON & BROS	., INC.
nysician		23a. Part / Enterthe disease, or compical ons that cause shock, or heart failure. List only one cause on each Immediate Cause (Final diseas or condition	od the death. Do not en line.	10000000	eh as cardiac or		est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	s a consequence of):					
	Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or a	s a consequence of):					
hysician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a	s a consequence of):				,	
a de s	Completed by Physician/Med		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
quires that n signed b uld be deta	d by PI	Part ff. Other significant conditions contributing to death Hyper leaster Revail FA	but not resulting in the c	underlying cause given in	Part I.			ite to the cause of death? □ Probably 4 🏋Unkno
has b	omplete					24a. Was a autops perform	y prio ned? dea	re autopsy findings availa r to completion of cause th? Yes 2 \(\subseteq\) No
yeicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?			Place of Death			
ng Phye fter this ineral dir	2	1 ☐ Yes 2 M No Hospital: 1 ☐ Inpa 27. Manner of Death 1 M Natural 5 ☐ Pending 28a. Date of In (Month, D	the state of the s	of 28c. Injury at Work?	28		ence 6 ①Other (ow injury occurred	(Specify)
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funerel Director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of f	njury - At home, farm, s etc. (Specify)	M 1 ☐ Yes		8f. Location (St City or Town	treet and Number (n, State)	or Rural Route Number,
e Hospite 24 hours e Funerel letely filled	ledical C	29a. Certifier (Check only one) 1 Certifying Physicien To the besis and manner.	of examination and/or is					
To th To th compl	Me	29b. Signature and title of certifier		29c. License nun	mber	2	9d. Date signed (A	
), Voleum	2	MO 5	1) P 8EB	and from)	8-6.04
		30. Name and address of person who completed cause of JEFFERY T. HOECK, M.D.	417	o, Print) 75 NORTH HAN	SON COUI	RT #203	A BOWI	E, MD 20716
Stat Registra		31. Date filed (Month, Day, Year) 32. Regin	strar's Signature	Sporks				

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State of Marylan	d / Department of Hi	ealth and Mental F	lvaiene

-05	033	-	For State Registrar		State of	Marylan	_	artment rtificate			and Me	ental Hyg	jiene leg. NO () () [.	25011
	Physici	an	1. Decedent's Name Robert		_ ′						- 1	2. Date of Dea Month August	Day	4 ^{Year}	3. Time of Death
}	/Medic Examin		4a. Facility Name (If		give street and number			4b. City,		Location			4c. County		
	Funeral Director		5. Social Security Nu 220-30-0340)	Sex 7	Age (In yrs. 172	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day March 16	, Year 1932	Cou	place (State or Foreign intry) yland
	show)r	Usual Residence of 10a. State MD	10b. County	N/A	10c. City	y, Town or Lo	ocation	B	altimo	re Cit	v			10d. Inside City Limits 15€Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmat be notified at	Director	10e. Street and Num		et, Apt 140			10f. Zip	Code	.201			10g. Citizen of	What Cou	•
920	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Marrie	ed 2 Marrie	12. Was Deced Armed Ford d XX Yes 2	ent Ever in U. es?		Was Deced If Yes, spec	ent of His	spanic Ori	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)	14. Rac	ce - Amer ck, White	ican Indian,
21215-0036	within 72 ho ene. than "natur he Medical	Completed	(Speci		Education grade completed) College (1-	4or 5+)	(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired)	luring mosi)	t of workin	g	16b. Kind of B		ndustry
land 2	d 2 should be filed within in and Mental Hygiene. 7 Is marked other than "r traumatic event, the Mes	To Be Co	17. Father's Name (ast)	0	real		TRALISC	18. Mothe	r's Name E Hube		Maiden Sumai		-
Maryland	ind 2 shou alth and M 27 is mar or traumat		19a. Informant's Na Roberta		p (Type, Print) e / Daughte i	•		-				Route Numbe	r, City or Town 1230	, State, Zi	ip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra <u>2005</u> 8.		° 4 ☐ Donation	Cremation : 5 Other (Sp.		tate Bay	lace of Disponentery, creation	matory or of	her place		ıst 5,	2004	20c. Location Baltimor		own, State faryland
Balt	permit. Departr Imports any inju		21. Signature et Fur	neral Service L	censee Victor	P. Doda		2. Name and narles 501 Fas	d Addres L• St t For	s of Facilit evens t Ave	Funera Tue, B	al Home, altimore	Inc. , MD 212	230	
	Physician /Medical Examiner	iner	23a. Part1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death) Sequentially list confidence in the cause. Enter Under Cause, (Disease or Cause, (Disease), (Dise	t failure. List o Final 1	b	the death ch line. Teusiver as a consequence as a conseq	U A+C		•	, .			lai Disa	asc	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	that initiated events resulting in death) L		c	r as a conseq	uence of):								
.O. Box 6	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	hysician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		th 2□Feta nt at time of d	Ideath 3	⊒Ectopic pro □ Other (sp						ate of deliventh	very Day Year
Δ.	w requires that been signed by should be deta	by P	Part II. Other signifi	cant condition	s contributing to dea	ath but not res	ulting in the u	inderlying ca	ause give	en in Part I		23e. Did to			the cause of death?
Vital Records,		Completed											an 24b. sy med? 2 \(\text{No} \)	Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
/ita	Physician: The this certificate ral director, pag	Be	25. Was case reference examiner?		Hogaital				Otho	N 100		(Check only o			
of	this aldi	2	1 Yes 2 ☐ 27. Manner of Death				ER/Outpatie			4 🗆 190			ence 6 Qti		(b) Scene
Division	Attending death.	Certification:	Natural 2 Accident 3 Suicide 4 Homicide	5 Pending investig: 6 Could n determine	ation	of Injury - At hog, etc. (Specif	Injury	М		(? /es 2 □	No		treet and Num		ral Route Number,
	d hours thours funeral ety filled	edical Ce	29a. Certifier (Check only one)		Physicien: To the xeminer: On the ba and mann	sis of examina									
	To the within 2. To the I complete	Me	29b. Signatu 9 and	title of certifier	w (M		290	: License				29d. Date signe Augus t		
ſ	b		30. Name and addr	2.140	Xan Al	of death (Item		Print) 111 Pe	enn S	Stree	t, Ba	altimor	e, Mary	land	21201
	St Regist	ate rar	31. Date filed (Mon	9 2004	Se ser	gistrar's Sign	Rure	rocks	/						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Marion Hickman AUCUST 2004 2-35AM 2 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE AMME ARUNDE Ciren 10PH AZUNDAL HOCITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 76 Director 220-20**-**1762 Feb. 9, Maryland Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant. The Nedical Examinar must be notified at 1 ☐ Yes 2√2No Director Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1301 Odenton Road 21113 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1950-70 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Master Sergeant U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be David Hickman Lottie Slaughter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If itam 27 ta any injury or other trau once. Michael Donahue (Friend) 1298 Gill Street, Odenton, MD 21113 20a. Method of Disposition

12 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ^¹ 4 □ Donation 5 □ Other (Specify) Epiphany Cemetery 8-6-2004 Odenton, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Doensee 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AFOMIC OBCTRUCTIVE TULMOURK. **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** ELEBRO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 2 No 2 No 1 Yes 1 Tyes Hospital or Attanding Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funaral Dirac 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 545149 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSP O GLENBURNIE MIS 21061 30B01 501 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 9 2004 Registrar Darkon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #10e PER FH G834 Sertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JENKINS ATRICIA 2004 406-UST /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALLSTOWN HOSPITAL NORTH WEST BALTIMORE Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAY 3, 193 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2XF Yrs. 68 218-32-6966 1936 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neture!" ~ ... any njury or other treumatic average. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔼 No Funeral Director Maryland Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 123 Deer Park Road 21117 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ê No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Homemaker Home 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob Wilson Jenkins Eleanor Pletzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Susan Hunt Daughter 1799 Dennings Road New Windsor, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lake View Mem. Park | Aug. 10, 2004 ' 4 □Donation 5 □ Other (Specify) Sykesville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 28a. Part 1. Enter the disease, or complications that edused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Imprediate Cause (Final RENAL ARTERY STENOSIS **Physician** SEVERE disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 🗆 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SEVERE ATHERDSCLEADTIC CARDIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 2 1 🗌 Yes 1 Inpatient 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation of or Attending after death. 1 ☐ Yes 2 ☐ No 6 Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aft To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certi P57722 - M-D. AUGUST 6 2004 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

LEUNARD RICHARDSON M.D.

31. Date filed Along Ty, 902004

32 Registrar's Signature

5401 OLD COURT RUAD RANDALLSTOWN, MARYLAND 21133

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2004 9:50 Jimenez August Rosendo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel Fairfield Nursing Center Crownsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 29,1935 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1(**X**M 2□ F 68 212-32-3571 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a, State in then "neturel", or Itams 23a or 28e-f show the Maxical Era alter must be notified at 1 ☑ Yes 2 ☐ No **Funeral Director** MD Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 130 Hearne Road. Apt. 809 21401 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking other t 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should ba file Department of Health and Mental Hy important: If item 27 is marked othen eny injury or other treumatic event, 9002s. 17. Father's Name (First, Middle, Last) Be Joseph M. Jimenez Mary F. Maglitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Matheson (Sister) 130 Hearne Road, Apt. 809, Annapolis, MD 21401 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town, State 1 □ Burial 2 Cremation 3 □ Removal from State Metro Crematory 8-7-2004 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or camplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINSONIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on: Examiner burial-transit be exacuted that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical as the IF FEMALE 23c. If ves. outcome of pregnancy 23d Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death Month Day Year signed by the atte d be detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After t Certification: or Attending 5 Pending investigation t-⊟Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funerel C 1 cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifip D23450 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HUNCH LA HYDES 5905 MO 32. Registrar's Signature Registrar

Steph 04-05

ner 504	ı Knepp∈ .2	er		Please	Type or Pri					=		_		
			1 - For State Registrar		State of M	aryland / D		rtment of F		Mental H	ygien Reg. N	001	250	15
	Physicia /Medic		1. Decedent's Nam	e (First, Middle, Las	et)			KNEP	PER	2. Date of I Month Augus		^{ay} 2004 ^{ar}		of Death 6 Р м
\ 	Examin Funeral Director		4a. Fecility Name (Sinai HC 5. Social Security N 215-42-13	ospital	e street and number) ex 7. Ag	ge (In yrs. last birth	hday) Yrs.	4b. City, Town, of Baltin If Under 1 Year Months Days		s. 8. Date of E	Birth	9 Birth	N/A pplace (State untry) N.Y	or Foreigi
	land ow		Usual Residence of	f Decedent 10b. County		10c. City, Town	or Lo	cation					10d. Inside	
	e Mary le-f sho	ctor	MD	BALTIMO	RE	OWINGS	MI	LLS					1 □ Ye	s Man
	with th	Dire	10e. Street and Nu		A D			10f. Zip Code				itizen of What Co	untry?	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 271s marked othar than "natural, or Itama 23a or 28e-f show or othar traumetic avant, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status	RBROOK RO	12. Was Decedent Armed Forces: 1Yes & If Yes, Give Year or Dates:	Ever in U.S.	li li	21117 Vas Decedent of Fires, specify Cub	an, Mexican, Pue	Specify Yes or to the Rican, etc.)	- L	.S.A. 14. Race - Ameri Black, White	e, etc.	
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, Maryland	1 and 2 should I Health and Men am 27 Is marken other traumetics			ame/Relationship (i		g Address (Street			•	or Town, State, Z		02143
Baltimore,	Pa Int:		20a. Method of Dis X1 ☐ Burial 2 `4 ☐ Donation		Removal from State	BALTIMO	Dispo RE	HEBREW C	ONG. 8/6	Date	20c. l	ocation - City or TERSTOWN	Town, State	
Balt	permit. Pag Department Important: I any injury o		21. Signature of E	uneral Service Licer	See		22	. Name and Addre	ess of Facility SC	L LEVIN	SON	& BROS.,	INC.	
3760,	Medical Examiner (Medical Examiner)	Ical Examiner	23a. Part I. Enter shock, or heal mmediate Cause disease or condition resulting in death) Sequentially list or if any, leading to incause. Enter Unit Cause (Disease on that initiated event resulting in death)	enditions, mediate signings	b. Due to (or as	d the death. Do not ine. Sclerotic a consequence of a co	c C				arrest,		Approxim Interval Bi Onset and	etween
.O. Box 687	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	! months? □No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pregnanc Other (specify)	у			23d. Date of deli Month	very Day	Year
rds, P.	quires that n signed b	by	Part II. Other signi	ficant conditions o	ontributing to death t	out not resulting in	the ur	nderlying cause giv	ven in Part I.			use contribute to		f death?]Unknown
Il Records,	. The law requires that the cate has been signed by th page 2 should be detache	Completed								24a. We aud per 1 \(\text{Yes}	topsy rformed?	death?	topsy finding completion of	s available cause of
Division of Vital	To the Hospitel or Attanding Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case refe examiner? 1 X Yes 2 C 27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide] No		ury 28b. Ti	ime of	28c, Injui Wo M 1	ner: 4 ☐ Nursing	28d. Describ	sidence e how inju	nd Number or Ru		ımber,
Q	To the Hospitel or within 24 hours after To the Funaral Dirth completely filled in the completely filled in the completely filled in the complete of the compl		29a. Certifier (Check only	1☐ Certifying Ph	ysician: To the best niner: On the basis of	of my knowledge,	, death	occurred at the ti	me, date and place	ce, and due to th	ne cause(s) and manner as	stated.	n(s)
)	To the within 2 To the complet	Medical	one) 29b. Signature and		and manner st	tated.		29c. Licens			29d. D	ate signed (Month	n, Day, Year)	
1	12		30. Name and add	_ , , ,	completed cause of	death (Item 23a) (Print) 1 Penn S	treet, E	Baltimor				
	Sta Registr		31. Date filed (Mor	9 2004	32. Regist	rar's Signature	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Lamb August 2004 7:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 130 Gibson Road Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Sept. 27,1927 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2XX 76 216-24-3971 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Is marked other than "neturel", or Iteme 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits arthan "neturel", or Iteme 23a or 28a-f show XXYes 2 □ No Completed by Funeral Director Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code **USA** 130 Gibson Road 21401 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Brady Margaret L. Norfolk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Lamb (Son) 1180 Summitt Drive, Annapolis, MD 21401 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Important: If eny Injury or once. `4 ☐ Donation 5 ☐ Other (Specify) 8-9-2004 Hillcrest Cemetery Annapolis, MD 21. Signature of Fungual Section Consee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician HRONIC YEARS iVE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Medical Certification: To 5 X Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Discribe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho To the Function and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MM AUG 0 9 2004 31. Date filed (Month) 32. Begistrar's Signature State Registrar

			1 - For State Registrar	State of N	/larylan		artment			and M	ental Hy	giene	1000	250	17
			Decedent's Name (First, Middle, La	ıst)							2. Date of De	eath	- U 13	3. Time o	f Death
	Physic /Medi		Maria Dolores	Lambdin							August	: 6 ^{ba}	¹⁹ 2004 ^{Year}	7:35	РМ м
7	Examir		4a. Facility Name (If not institution, given Cilobaiat Numai		r)		4b. City,	Town, or	Location o	of Death		40	. County of Dea		
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	Funeral Director			Gex 1□M 2 ∏ F 7. A	85 85	last birthday) Yrs.	Months	Days	If Under:	Min.	8. Date of Bir (Month, Da	ay, Year,		thplace (State ountry)	or Foreign
			Usual Residence of Decedent	, , , , , , , , , , , , , , , , , , ,	- 00						July 7,	1919	Mary	land	
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	the Ma 28a-f	Director	MD N/A			Baltimo								X	2 🗆 No
	with the		10e. Street and Number				10f. Zip						tizen of Whal Co	ountry?	
	eath w	Funeral	5404 Plainfield Aver	12. Was Deceder	nt Ever in II	S 13 V		1206	enanie Orie	nin2 (Sne	cify Yes or No		S. A. 14. Race - Ame	rices Indian	
(0			1 Never Married 2 Married	Armed Forces	s?		fYes, spec	ify Cubar	n, Mexican	, Puerto I	Rican, etc.)		Black, Whit		
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an	ld be ental ked o	To Be	Clarence Morningsta								Hughes	, waaroor	oumane,		
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	alth a		Paul J. Lambdin - S	on			rks Far				, Maryla				
Baltimore,	ges 1 and 2 t of Health If item 27 or other tre		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Bamayai from Stat	I ~	lace of Dispo emetery, cren	sition (Nam	e of her place)	D	ate	20c. L	ocation - City or	Town, State	
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3all	permit. Departm Importer any inju		21. Signature of Fund I Service Line	Michael /	J. Ruck	, Sr. ²²	. Na <i>m</i> e and	d Address	s of Facility	· I			ck, Inc.		
	70 = e o	\vdash	Menery	KENZ, N	-	!	5305 Ha	rforc	Road	Balt	imore. M	arvla	nd 21214		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	one cause on each	ed the death line.	Do not enti	er the mode	of dying	, such as	cardiac oi	respiratory a	rrest,		Approximat Interval Bet Onset and	ween
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	Examiner				s a consequ		. (اد مران	
		e.	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	0.	s a consequ	2	And							Jun	
	outed d ansit	Examiner	Cause (Disease or injury that initiated events	chr	onic	065	truck	! ive	Lun	g di	sease			المحا	سب
oʻ	an an an rial-tr	Exa	resulting in death) Last	Due to (or a						-			-	-0	
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9	entific ling p	Mec	IF FEMALE:	00.16											
Вох	The law requires that the death certific site has been signed by the attending p page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3 [Ectopic pre						23d. Date of deti Month		fear
P.O.	the de	ysic	1 ☐ Yes 2 D No 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time of de	atn 5∟	Other (spe	city)						,	
	uires that the de signed by the a Id be detached f		Part II. Other significant conditions of	ontributing to death	but not resu	liting in the un	derlying ca	use giver	n in Part I.		23e. Did to	obacco L	ise contribute to	the cause of d	eath?
Records,	quires n sigr	d by	COVMAY	grtery	dis	ease					1,521	res 2	□No 3□Pro	obably 4 🗆 L	Jnknown
00	w requires been si	jete	/	,							24a. Was	an	24b. Were au	topsy findings	available
Re	The lav	Completed				<u></u>			-			rmed?	prior to death?	ompletion of ca	ause of
Vital			25. Was case referred to medical						26. Place	of Death	1 Yes	2 🔯 No ine)	1 10195	2□ No	
of V	Attending Physicien: or death. ector: After this certificity the funeral director,	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpat	ient 2 🗆 E	ER/Outpatient	3 □ DO	Other	4 🗆 Nur	sing Hom	e 5 Resid	dence (6 ⊠Other (Spec	ity) Hase	i ce
טע	9 je je		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		c. Injury Work	at		8d. Describe h				
Division	Attendi death. ctor: A y the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not b				М		9s 2 □ N	-					
ا∑ار	after of Direct of Jin by	ertif	4 Homicide determined	280. Place of It	njury - At hor etc. (Specify)	me, farm, stre)	et, factory,	office		2	8f. Location (S City or Tox	Street an vn, State	d Number or Ru.)	ral Route Numi	ber,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		29a. Certifier 1 Cartifying Ph	ysician: To the bes	t of my know	vledne death	occurred a	t the time	date and	Diaco as	ad due to the	20100(0)	and manner on	stated	
	To the Hospite within 24 hours To the Funerel completely filled	Medical		niner: On the basis and manner s	of examinati	ion and/or inv	estigation, i	n my opi	nion, death	occurre	d at the time,	date and	place, and due	to the cause(s)	
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Me	29b. Signature and title of certifier	10			29c.	License	number			29d. Dat	e signed (Month	, Day, Year)	
			> M Arthon	, they,	no		1	25	205	_		409	UST 7	2004	
1			30. Name and address of person who	completed cause of	death (ttem	23a) (Type, F	Print)				0				
1)		W.A. Riley	6-3mc		01 1	. Ch	urlis	17.	80	Ste 1	md	0120	×	
	Sta Registr		31. Date filed (Moeth, Day, Year) AUG 0 9 2004	32. Regist	trar's Signati	Le J	long	1.1					e signed (Month		

August 6,3004

MARIE LAMBRIN

			1 - For State Registrar		State of M	Maryland		artment of H rtificate of		nd Me	ntal Hy	/gieņ		i 2	25018
	Physic	ion	Decedent's Name (First	t, Middle, Last)					2	. Date of D Month			ear	3. Time of Death
	Physic /Medi		Deborah					Leach-M	cCall		July_	3		004	4:53 A ^M
7	Exami	ner	4a. Facility Name (If not in			r)		4b. City, Town, o	r Location of E	Death		40	. County of	Death	
			Johns Hop					Balti					Balti		
	Funeral		5. Social Security Number	1 [x	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Bi (Month, D 1	rth ay, Year,	9	. Birthpla	ace (State or Foreign
	Director		219-76-274 Usual Residence of Dece	45		43	115.			(01 1	.7	61	Ŋ	4D
	riand ow			County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
	Man,	ģ	MD	NA		Bal	timor	е							1 X Yes 2 □ No
	r 28a	rec	10e. Street and Number					10f. Zip Code				10a. Ci	tizen of Wh	at Count	n/?
	h with	Funeral Director	4304 Seide	el Ave				21	206			_	U.S.		.,,.
	deat	ner	11. Marital Status		12. Was Deceden	t Ever in U.S	3. 13.)	Was Decedent of H		? (Specif	y Yes or N		14. Race -		n Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Exerting triast by notified at		1 Never Married 2		Amed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates	No	1	f Yes, specify Cubi	an, Mexican, P Specify:	uerto Ric	an, etc.)		Black, Specify:	White, ϵ	
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21	filed within Hygiene. Sther than ent, Ite Man	5	12th grade		na			Manager				Re	stau	cant	
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lar	2 sho		19a. Informant's Name/R					g Address (Street						te, Zip C	Code)
	1 and Health em 27		Robert Mc		usband			Seidel	Ave	Bal	timo	re	Md	212	206
Ore	Pages 1 nent of H int: If ite iry or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crer		demoval from State		ace of Dispo metery, cren	sition (Name of natory or other plac	:ө)	Date	9	20c. L	ocation - Cit	y or Tow	n, State
ij	tmen tant:		`4 Donation 5 □ C	Other (Specify)				morial			04	Ran	dalla	stow	n, Md
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr <u>90Ce</u> .		21. Signatura of Funeral S	Service License	"Kek	_	M 4	arch F/ 300 Wab	h West	t ve,	Balt	imo	re, I	1d	21215
			23a. Part 1. Enter the of se shock, or heart failur	ase, or compli	ications that cause	ed the death.	Do not ente	er the mode of dyin	g, such as car	diac or re	spiratory a	rrest.			Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition		HURRY	Hu Sil	so a	Herisc	Porch	' C	ardi	ê V4.	Suk		Onset and Death
	/Medical		resulting in death)	•	Due to (or a	s a conseque	ence of):	, ,		0	tista	-		+	
	Examiner		Sequentially list condition	s I t),										
	pe tis	lue	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	te 🚽	Due to (or as	s a conseque	ence of):								-
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to for a										
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-	eath certific attending p		IF FEMALE:	. 2	3c. If yes, outcome	e of pregnan	cv								
Вох	atter for u	clar	23b. Was decedent pregn in the past 12 month	Idill	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3 🗌	Ectopic pregnancy Other (specify)					23d. Date of Month		ay Year
O.	The law requires that the death cer lie has been signed by the attendin page 2 should be detached for use	Physician/M	1 Yes 2 No 9 Unknown		9□ Unknown			Olivor (Specify)							
σ.	s that ned b	by PI	Part II. Other significant of	onditions con	tributing to death I	but not result	ting in the un	derlying cause give	en in Part I.		23e. Did t	obacco u	se contribu	te to the	cause of death?
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000	aw requir 1s been si 2 should I	Completed	1+9 perco	o lest	tralen	nia					24a. Was	an	24b. Wer	e autons	y findings available
R	The la	mo l			4.7					-	autor perfo	rmed?	prior	to comp h?	letion of cause of
Vital		0	25. Was case referred to r	medical					26. Place of I	Death (C	1 Yes	2/2/10	1	Yes 21	□ No
>	dis Ys	0 8	examiner? 1 🙀 Yes 2 🗌 No	Н	ospital: 1 Inpati	ient 212 E	R/Outpatient	3□ DOA Othe	00				Other (Speciful	
J Of	ig Ph ter th neral	T:U	27. Manner of Death		28a. Date of Inju (Month, Da	ury 2	28b. Time of	28c, Injury	at		Describe i			эрөспу)	
0	Attending F r death. ector: After by the funer	atlo	1 Natural 5 2 Accident	Pending investigation	(Monar, De	ay roar/	Injury	M 1 🗆 '	res 2 □ No						
Division	of or Attend after death Director:	Certification	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of In	jury - At hom	e, farm, stre	et, factory, office		28f.	Location (S City or Tox	Street and	d Number o	r Rural R	Route Number,
	ital or rs afte al Dire	Cer			31 0						ony or rov	en, State,	,		
	To the Hospital or At within 24 hours after or To the Funeral Direction plately filled in by	edical	29a. Certifier 1 ☐ C (Check only one) 2 ☑ M	ertifying Phys edical Examin	sician: To the best ner: On the basis of and manner st	or examination	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date and planting of the pinion, death of	ace, and ccurred a	due to the	cause(s) date and	and manne place, and	r as state due to th	ed. e cause(s)
	To the within 2. To the I complet	Σ	29b. Signature and title of	certifier			,	29c. License	number			29d. Dat	signed (M	onth, Da	y, Year)
)	V.		· Lac	Til	lla 5	AK	*	OCME				Augu	st 4,	2004	
	M		30. Name and address of	person who co	mpleted cause of	death (Item 2	23a) (Type, F	rint)							
			215 131	146	14	172,		11 Penn	Street,	Bal	timor	e, M	aryla	nd 2	21201
	Sta Registr	_	31. Date filed (Month Day	9 2004		rar's Signatu	re Es	Smile							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Day **Physician** John Michael McCruden 2004 2:59 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 10104 Falls Road Brooklandville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 4/12/1942 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary land 10\ M 2□F 62 214-40-0962 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hyglene.

If it flam 2.7 is marked other than "natural", or items 23a or 28a-1 show or other traumatic avent, it a Macilcal Examins mail the notified an 10a. State 10b. County 10d, Inside City Limits Maryland Baltimore **Brooklandville** 1 Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10104 Falls Road 21022 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (Xes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or Item 1 Never Married 2 Married 1 ☐ Yes 2 No White altimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) Firefighter Balto. Co. Fire Dept. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Aloysius McCruden Aileen Marie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10104 Falls Road, Brooklandville, Md. 21022 Elizabeth Nuttle McCruden -Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State a □Donation 5 □ Ornel (Specify)

21. Signature of Fugural Softice Light 3 Removal from State Dulaney Valley Mem. Gdns 8/7/04 permit. Page Department of Important: If any injury or once. Timonium, Maryland ²² Name and Address of Facility Ruck Towson Funeral Home, I 1050 York Rd., Towson, Md. Ernest (L) Peist, III 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death stastatic Renal Cell Carcinoma Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably should Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 s autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Yes director. Be 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 1 Yes No 2 2 ER/Outpatient 3 DOA 5 X Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. ë 29c. License number Moule and 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier D31586 lamson 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nancy A. Dawson, MD , 22 S. Greene St, Suite S9D01 , Balto. Md. 21201 31. Date filed (Month, Day, Year) 32, Registrar's Signature State AUG 0 9 2004 Registrar

		For State Registrar		State of Ma	aryland / [Department of I Certificate of		Mental Hy	giene Reg. No	2001.	25020
		Decedent's Name	(First, Middle, La	st)				2. Date of De		- 107 tu/ 1	3. Time of Death
Physicia /Medica	al .		ria J.					Augu		2064	4:50A M
Examine	-	17 1	not institution, giv	re street and number)	pita	46. City, Town,	or Location of Death	2	4°	County of Deat	molp
Funeral Director		5. Social Security No. 215-46-		Sex 7. Ag 1 □ M 2 □ F	e (In yrs. last bir 57	Yrs. If Under 1 Year Months Days		8. Date of Big (Month, Da Sept.	25,	9. Birt Co 1946 Ma	hplace (State or Foreign juntry) aryland
pu ,		Usual Residence of			10c. City, Tow						
Maryla e-f shov	tor	10a. State MD	Baltim	ore		Rosedale					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
or 28	Dire	10e. Street and Nun		_		10f. Zip Code				izen of What Co	ountry?
s 23a	Fra		azelwoo	d Court	Ever in 11 C	212:		necify Ves or No	US.	A 14. Race - Ame	nican Indian
s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene, the marked other than "naturat", or items 23a or 28e-f show other treumatic event, the Madical Examination ust be mailtred at	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 Married	Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cul		o Rican, etc.)		Black, White	e, etc.
in 72 ho	Completed		15. Decedent's E	ade completed)		Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	a during most of wor	rking	16b. K	ind of Business/	Industry
Hygiene. Hygiene. Ither than	mo.	Elementary/Secon	ndary (0-12)	College (1-4or 5		Homemaker			01	wn hom	e
nd Mental Hyg marked othe imatic event,	BeC	17. Father's Name ((First, Middle, Last)	-		18. Mother's Nar	ne (First, Middle	, Maiden	Sumame)	
Mental arked c	2			d Bauers				s K. J			
ealth and n 27 is maser treums		19a. Informant's Na	•			. Mailing Address (Stree					
item 27 other tr		20a. Method of Disp	Martin	Jr. /so	20b. Place o	5512 Hazel f Disposition (Name of	1	Date Ba		MFOE M. ocation - City or	
nent of h		1 /2 Burial 2 [Removal from State	cemete	ry, crematory or other pla awnCemeter		/04		ltimor	
		21. Signature of Fu			100	22. Name and Addr	ress of Facility C	onnell	vFur	neralHo	meofEssex
Departr Importa any inj	Ì	► / ·	Terri	Lonn	elle	300 M	lace Ave				
		23a. Part1. Enter the shock, or hear	ne disease, o	plications that caused one cause on each li	the death. Do	not enter the mode of dy	ring, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
hysician		Immediate Cause ((Final n	a cordi	0 Re	SPIPONTOI	OX ACC	e5+			Onset and Death
/Medical xaminer		resulting in death)	(Due to (or as	a consequence	of):	<u></u>				
	<u>-</u>	Sequentially list cor	nditions,	b. Serol	a consequence	of):					
ansit	Examiner	Cause, Enter Unde Cause (Disease or	injury	Borct	rial	Perito	iti5				
ysician and e burial-transit		that initiated events resulting in death) L	Last		a consequence						
physicia the but	dicai		•	d. CIrrh	0515				~		
attending physi	n/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome		•□= :				23d. Date of del	ivery
ed by the atte detached for	Physician/Medio	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	1∐Live birth 4∏Pregnant a 9☐Unknown	2 ☐ Fetal death t time of death	3 □Ectopic pregnant 5 □ Other (specify)	cy			Month	Day Year
ate has been signed by the attending phys page 2 should be detached for use as the		Part II. Other signif	icant conditions	contributing to death b	out not resulting i	n the underlying cause g	iven in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
	Completed by	HePati	z-Ken	al syn	glow.	2		1 🗆	Yes 2	□No 3□Pr	obably 4 Munknown
has been ge 2 should	piet							24a. Was		24b. Were au	itopsy findings available
page	mo:							perfe	ormed? 2. No	death?	2□ No
is certificate hadirector, page	Bec	25. Was case refer examiner?	red to medical				26. Place of Dea	ath (Check only	one)		
his ce I dire	2	1 Tes 2	No	Hospital: 1 Inpatie		atpatient 3 DOA	The least to	lome 5 Res			cify)
ath. r: After ti e funera	ation:	27. Manner of Deati 1 Natural 2 Accident	h 5 Pending investigation	28a. Date of Inju (Month, Da	y Year) 28b.	Time of 28c. Injury William 1	ury at ork? ⊒Yes 2 □ No	28d. Describe	how injur	ry occurred	
To the Funeral Director: After the completely filled in by the funeral	Certification:	3 🗌 Suicide 4 🗌 Homicide	6 Could not I determined	289. Place of In	ury - At home, fa c. (Specify)	arm, street, factory, office	9	28f. Location (City or To			ıral Route Number,
within 24 hours after death. To the Funeret Director: After this completely filled in by the funeral di	edicai C	29a. Certifier (Check only one)	1 Certifying P	hysicien: To the best iner: On the basis of and manner st	f examination ar	e, death occurred at the nd/or investigation, in my	time, date and place opinion, death occu	a, and due to the arred at the time,	cause(s) date and) and manner as d place, and due	stated. to the cause(s)
within 24 hours after death. To the Funeret Director: After this certific completely filled in by the funeral director,	Me	29b. Signature and	tille of certifier			29c. Licer	nse number		29d. Da	te signed (Monti	h, Day, Year)
, n		> 10/	Wast.	10		05	5625		A	45h St 4	2004
9		30. Name and dd	ss of erso	completed cause of	death (Item 23a)		e Drive	Balt	ima	Co MI) 11777
		31. Date filed (Mon		21 9 000 F	rar's Signature	11 24 M	PIVE	12011	1110	10,111	0/00/
Sta	to i	91 410 1100 (111011									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Not 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** MYERS 06.50 PM JEANNETTE 2004 AUG1UST 0.5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE HARBOR N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)

January 11, 1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 72 Months 1 □ M 2**XX** 216-28-5324 MD Director Usual Residence of Decedent s and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD N/A Baltimore City 1 XX es 2 No Be Completed by Funeral Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1410 Decatur Street 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z Mo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX0 Specify: white 3 Widowed 4XXDivorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Import / Export Administrative Assistant 17. Father's Name (First, Middle, Last)
Frank Walter, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Virginia McKay 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Reed / Daughter 1410 Decatur Street, Baltimore Maryland 21230 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If iten any njury or oth once. Bayview Crematory or other place)

Bayview Crematory, August 10, 2004 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS DAYS **Physician** /Medical Due to (or as a consequence of): SURGICAL ANASTAMOTIC LEAK Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PNEUMONIA ASPIRATION attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. HEART FAILURE ONGESTIVE Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò RENAL INSUFFICIENCY 1 Yes 2 No 3 Probably 4 Unknown Completed ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 W No 24a. Was an autopsy performed?/ Yes 2 No METASTATIC GASTRIC ADENOCARCINOMA or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: Af completely filled in by the fur death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES 001 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MARYLAND 21225 STREET, 32. Registrar's Signature State Registrar

			State of Maryland	l / Depa	artment of Health and I tificate of Death	•	
>	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last) Lena B. Marani 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	2. Date of Death Month August 4, 2	Day Year 3. Time of Death 9:25 P M 4c. County of Death
	Funeral Director		Stella Maris 5. Social Security Number 215-07-0686 Usual Residence of Decedent	st birthday). Yrs.	TOWSON If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea April 28, 19	Baltimore 9. Birthplace (State or Foreign Country) Pennsylvania
	the Maryland 28e-f show	Director		Town or Lon		100	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or tiems 23e or 28e-1 show evant. I're Medical Exercil er mast be rediffed at	Funeral Dir	1699 Wilson Point Road 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	. 13. V	21220 Vas Decedent of Hispanic Origin? (Sin Yes, specify Cuban, Mexican, Puert		USA 14. Race - American Indian, Black, White, etc.
15-0036	72 hours aft "netural", or edical Exercit	Completed by F	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a, Deced	Yes 2 No Specify: ent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king 16b.	Specify: White Kind of Business/Industry
Maryland 21215-0036		Be	Elementary/Secondary (0-12) 6th N/A 17. Father's Name (First, Middle, Last) Vincenzo Basignani		nemaker 18. Mother's Nam	ne (First, Middle, Maid	Own Home
	is 1 and 2 should be of Health and Mental itam 27 is marked to other traumatic even	To	19a. Informant's Name/Relationship (Type, Print) Albert R. Marani/Son	1699 N	Agnese Le g Address (Street and Number or Ru Wilson Point Road Bal	ral Route Number, City timore Maryla	
Baltimore,	permit. Pages 1 an Department of Heali Importent: If itam 2 any injury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Holy F	Name and Address of Facility		timore Maryland
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	Do not ente	scolor Ilis	or respiratory arrest,	Approximate Interval Between Onset and Death
3760,	Examine be executed hysicien and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	nce of):	frees		
.O. Box 68	that the death certificate ed by the attending phys detached for use as the	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Δ.	The taw requires that the tee bas been signed by the base been signed by the bage 2 should be detache	ted by PI	Part II. Oth spinificant conditions contributing to death but not result	ing in the un	derlying cause given in Part I.		o use contribute to the cause of death?
Vital Records,		e Comple	25. Was case referred to medical			24a. Was an autopsy performed?	
of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	To B	examiner? 1 Yes 2 0 Hospital: 1 Inpatient 2 Ef	VOutpatient 8b. Time of Injury	Other -	th Check onl one ome 5 Residence 28d. Describe how in	
Division	ital or Atta us after ded ral Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rural Route Number, ite)
	thin 24 hou thin 24 hou the Fune impletely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl (2 Meght all Examiner: On the basis of examination and manner stated. 29b. Signature and the of certifier	edge, death n and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur 29c. License number	red at the time, date a	(s) and manner as stated. Indiplace, and due to the cause(s) Date signed (Month, Day, Year)
)	F3F8		30. Name and address of person who completed cause of death (Item 2	(3a) (Type F	9) 1450		are signed (worth, Day, Tear)
D	Sta	te	EDDIE NAKHUDA, M.D. 2300 DU	JLANEY		MONIUM MI	21093
	Registr		31. Date file A Moch, Day Year 104	1 12	your		

9:25 P.M.

AUGUST 4, 2004

MARANI, LENA

			1 - For State Registrar	State of M	•	epartmen Certificat			nd Mental H	/giene Reg. NG.		25023
			1. Decedent's Name (First, Middle, Last)						2. Date of D		V	3. Time of Death
	Physici /Medi			Olan	Lerov	McLa	uah 1 i	n, Sr	. Augus	Day t 5. 20	Year 004	6:39 AM
7	Examir		4a. Fecility Name (If not institution, give s	street and number)	10101			Location of			unty of Death	
			7847 North Cove R	oad			Edge	mere			Baltin	nore
	Funeral		Social Security Number 6. Sex		e (In yrs. last birtl		1 Year	If Under 24	Hrs. 8. Date of B	irth	9. Birth	place (State or Foreign
	Director		185-16-7943	IM 2□F {	3 Y	rs. Months	Days	Hours	April	irth ay, Year) 24,192	21 Penr	nsylvania
	p. ,		Usual Residence of Decedent									
	show	_	10a. State 10b. County		10c. City, Town	or Location		Edgam	0200		1	Od. Inside City Limits
	ith the Marylan or 28e-f show	ct		imore				Edgem	ere			1 ☐ Yes 2 🛣 No
	ij	Funeral Director	10e. Street and Number			10f. Zip				-	of What Cour	•
	ath w	rai	7847 North Cove R	oad				21219			ted Sta	ites
	after des	Tue		12. Was Decedent Armed Forces?		13. Was Deced If Yes, spec	dent of His	spanic Origir n, Mexican, F	n? (Specify Yes or N Puerto Rican, etc.)	0- 14.	Race - Amend Black, White,	
36	or t	by Fi	1 Never Married 2 Married	1 XXes 2 □ I If Yes, Give		1 🗆 Yes		Specify:			ecify:	
21215-0036	within 72 hours after death with the Maryland one. than "natural", or items 23e or 28e-f show the Madical Examinar must be notified at	q p	3 Widowed 4 Divorced	Year or Dates:								White
5	"nat	Completed	15. Decedent's Educ (Specify only highest grade	cation com <i>pleted)</i>	16a. I	Decedent's Usua (Give kind of wo life. DO NOT us	al Occupat rk done du	tion <i>uring</i> most o	of working	16b. Kind o	of Business/Ind	dustry
12	withii ene. than	E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Car Rep				C+	ool Ind	l., c+ v.,
9	tould be filed via the filed variety of the filed variety of the filed variety that it is natic event, its		12 Years 17. Father's Name (First, Middle, Last)			car ne	- 1		s Name (First, Middle		eel Inc	ustry
an	d be	Be C	Ethelbert McLaugh	lin					Hidler	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, in the second	
Maryland	2 shoutd be filed withir and Mental Hygiene. Is marked other than aumatic event, the Ma	2	19a. Informant's Name/Relationship (Type		a 19h	Mailing Address	(Street ar		or Rural Route Numi	or City or To	um Stato Zin	Cadal
Ma	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at		Mrs. Myrna E. McL						ad Edgem			•
Ģ	is 1 and 2 if Health item 27 other tr	Ш	20a. Method of Disposition		20b. Place of	Disposition (Nar.	ne of	1	Date	20c. Locati	on - City or To	own. State
Baltimore,	Pages nent of h ant: If its ury or of		1 Burial 2 □ Cremation 3 □ R	emoval from State		crematory or o, of Fait			9/2004			Maryland
華	- 525		*4 □Donation 5 □ Other (Specify) 21. Signature Funeral Service License	. 0	Guis.						-	-
Ba	Depa Impo eny ir		Al con		~	Duda	-Ruck	Fune	ral Home	of Dunc	dalk, I	inc.
	_		23a. Part1. Enter the disease, or compli	cations that caused	the death. Do no				Dundalk		Land 2	21222 Approximate
			23a. Part1. Enter the disease, or complishock, or head billure. List only on Immediate Cause (Final	e cause on each li	ne.		//		_	111031,		Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)		Longes	tur	1704	ut 7	adies			340
	Examiner			Due to (or as	a consequence of	1):	1.1	A	Tadies			11
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of		7	Ols	run,			13955
	ited insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,	, ,						
	be executed sician and burial-transit	Xa	that initiated events cresulting in death) Last	Due to (or as	a consequence of	f):			-			
8760,	death certificate be executed e attending physiclan and od for use as the burial-transit											
89	ficate I physics the b	Physician/Medical										
ŏ	leath certific attending pl	W/u	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome		_				23d.	Date of delive	erv
m	death a atte	Cia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ∐ Live birth 4 ☐ Pregnant at	2 Fetal death time of death	3 □Ectopic pr 5 □ Other (sp						Day Year
0	at the de by the tached	hys	9 Unknown	9L]Unknown								
٦,	The law requires that the the has been signed by thoage 2 should be detached.	by P	Part II. Dther significant conditions con	tributing to death b	ut not resulting in	the underlying c	ause giver	n in Part I.	23e. Did	tobacco use d	contribute to th	e cause of death?
rds	quire in sig uld b		Chronu Ken	I Insu	Hickory				1 🗆	Yes 2□N	o 3 ☐ Prob	ably 4 Unknown
Records,	law requir as been s 2 should	Completed	Chronic Obch	rutin	Pulmo	nas 1)	secu	••	24a. Was	an 24	b. Were autor	psy findings available
B	The la	E						-7		psy ormed?	prior to cor death?	npletion of cause of
Vital		0	25. Was case referred to medical					26 Place of	1 ☐ Yes Death Check onl	20 10	1 🗆 Yes	2 No
>	Physician: this certific ral director,	OB	examiner?	ospital:	ent 2 ER/Out	patient 3 DO	Other		ng Home 5 ☐ Res		Other /Specific	(1
1 0		E I	27. Manner of Death	28a. Date of Inju		me of 2	8c. Injury a Work?		28d. Describe			/
o	Attanding In death. ector: After by the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORLI, DE)	y / 6a/)	ury M		es 2□No				
Division		iific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At home, farr	n, street, factory	, office		28f. Location	Street and Nu wn, State)	mber or Rura	Route Number,
Ö	spital or A ours after neral Direc filled in by	Certification;		bullarily, bu	o. (Opachy)				City of 70	wn, Siate)		
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying Phys	ician: To the best	of my knowledge,	death occurred	at the time	, date and p	place, and due to the	cause(s) and	manner as st	ated.
	To the Hos within 24 h To the Fur completely	edlcai	(Check only 2 Medical Examin	and manner sta	ted.	or investigation,	in my opii	nion, death i	occurred at the time,	date and plac	ce, and due to	the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Σ	29b. Signature and title of certifier				. License			29d. Date sig	gned (Month, L	Day, Year)
•	\		Mela lil	Un-	_ /	1	1)	3055	5	Uun	it 5	2004.
1)	1		30. Name and address of person who con	mpleted cause of d	eath (Item 23a) (T	ype, Print)	1.	,		0		7
)	1		Alea N. Don		756	North	/le in	1 Rd	, Bali	mus	sus	21219
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9 2004	32 Registra	ar's Signature	Space	KN					

			1 = For State Registrar	State of Ma	arylan		artmen rtificate					Reg. Nø	001	2502	
	Physici	an	1. Decedent's Name (First, Middle, Las	-							2. Date of De	Day	, 2004 Yee	3. Time of Dea	
20	/Medio		Verna E. Minnin 4a. Facility Name (If not institution, give				4b City	Town or	Location o		August		County of De	11:45 A	- A ™
	Examir	ıer	15311 Beaverbrook		2 G				pring				ontgom		
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs.	last birthday)	If Under Months	1 Year	If Under a		8. Date of Birt			Birthplace (State or For Country)	reign
	Director		4/3-12-319/	□M 2 X 0F	90	Yrs.	Months	Days	Hours	Min.	8. Date of Birl (Month, Da April 27	, 191	4 Mi	nnesota	
	and		Usuel Residence of Decedent 10a. State 10b. County	· · · · · · · · · · · · · · · · · · ·	10c. Cit	y, Town or Lo	cation							10d. Inside City Lir	mits
	Maryl f sho	ō	Maryland Montgom	erv	Si1	ver Sp	rino							1 ☐ Yes 2 🔯	
	r 28e	Director	10e. Street and Number			.vor op	10f. Zip	Code				10g. Citi	zen of What	Country?	
	th with	al D	15311 Beaverbrook	Court, #2	2 G		20	906				Uni	ted St	ates	
	ems dems	Funeral I	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Was Deced	ent of H	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ar Black, W.	merican Indian,	
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☑ 1 If Yes, Give	No	İ	1 ☐ Yes 2		Specify:		,,		Specify:		
Ö	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show lical Examiner must be motified at	q pa	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a. Dece	dent's Usua	I Occup	ation			16 K		White	
<u>7.</u>	n "ne	Completed	(Specify only highest gra-	de completed)		(Give	kind of wor DO NOT us	k done d	lurina most	t of workin	g	166. KI	nd of Busine:	ss/industry	
212	d within giene. or then "	mo	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Homem	aker					0	wn Hon	ne	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Hygiene. d other then "neturel", or Items 23e or 28e-f show event, Ite Maolical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
ylaı	should be tind Mental I ind Mental I is marked or umatic eve	To	Richard Lahn						Marga	aret	Sander	S			
Jar	0 0 0 0		19a. Informant's Name/Relationship (7			19b. Mailir	ng Address	(Street a	and Numbe	or or Rural	Route Numbe	r, City o	r Town, State	, Zip Code)	
e) O	1 and 2 Health tem 27		William R. Minning	g/ Son	20b B	5621 Place of Dispo			Road		thesda				
סר	ages nt of h		1 ☐ Burial 2 🖾 Cremation 3 🗆		C	emetery, crer Monte	natory or or omerv	her plac						or Town, State	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other 2005.		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Lice)	- 1	Cre	matorĭ	um, I	nc.						Maryland Tuneral Hom	/
Ba	Depa Depa Impo eny ir		M/m/		1689									Avenue,	ie/
	nysician /Medical Examiner	ner	23a. Part. Enter the disease, or companies of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the Enter the cause (Disease or injury)	a. Myocardi Due to (or as Hyperten Due to (or as	al I a conseq ision	n. Do not ent nfarct uence of):	er the mode	e of dyin	g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death Hours	
2	death certificate be executed e attending physician and id for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant at	of pregna 2	incy	Ectopic pro						23d. Date of c	delivery Day Year	
о. О.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown	tillio or di	eaui J	J Other (Spe	9cny)							
	requires that the sen signed by th hould be detache	by Pt	Part II. Other significant conditions co	ontributing to death be	ut not resi	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contribute	to the cause of death?	?
<u>5</u>	w require: been sig should by	leted b	Hypercholesterole	emia							1 □ Y	es 2	¥No 3□	Probably 4 Unkno	own
၀ ဂ	> 10 0	plet									24a. Was		24b. Were	autopsy findings availa	able
ř	The lavate has	Compl										sy med? 2 √ No	death'	o completion of cause ? es 2□ No	10
Vital Records,	ysicien: The is certificate ha director, page	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
ō	ding Ph h. After th funeral	2	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatien 28b. Time of Injury		Bc. Injury Work	4 🗀 1401	2	e 5⊠ Resid 8d. Describe h			pecify)	
	P # # #	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At ho	ome, farm, str	eet, factory	, office		2	8f. Location (S City or Tow	treet and n, State,	d Number or	Rural Route Number,	
	the Hospitel hin 24 hours a the Funerel E	edical	one)	ysician: To the best of iner: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred a vestigation,	at the tim	e, date and pinion, deat	d place, and the occurre	nd due to the o	ause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
ı	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c	. License	number			29d. Date	e signed (Mo	nth, Day, Year)	
			4			-mr	2	D432	.02			lugu	st 4,	2004	
É			30. Name and address of person who con Charlene Ozanne-BJ	1				Lei	sure	Wor1		S	ilver	Spring, nd 20906	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra								, ,			_
	Registr	ar	AUG 0 9 20	104 Sen	eva	9	10	our	21						

		•	For State 1 - Registrar	ate of Maryland / Dep Ce	ertificate of I			iene	25025
			1. Decedent's Name (First, Middle, Last)				2. Date of Death	Day Year	3. Time of Death
	Physici: /Medic		Anthony William Mora	azzano				2004	9:15 P ^M
	Examin		4a. Facility Name (If not institution, give street	and number)		r Location of Deat	h	4c. County of Death	h
			3806 Pinewood Ave.		Balti			N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)	Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) Coi	nplace (State or Foreign untry)
	Director		214-26-8744 X	74 Yrs.			Sept. 2	8,1929 0	hio
	and w		10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
	Mary 1 sho	ō	Md. N/A	Baltim	ore				1 Yes 2 No
	the 28a	Je C	10e. Street and Number	Darcin	10f. Zip Code		10	ng. Citizen of What Co	untry?
	3a or	Funeral Director	3806 Pinewood Ave.		21	206		U.S.A.	
	death	Jera	11. Marital Status 12. W	as Decedent Ever in U.S. 13 med Forces?	Was Decedent of H	lispanic Origin? (S	Specify Yes or No-	14. Race - Ame Black, White	
9	or ita			Tes 2 □ No Yes, Give	1 ☐ Yes 2 No	Specify:	10 1110411, 010.7	Specify: Wh	
93	i within 72 hours after death with the Maryland liene. I than "natural", or flams 23a or 28a-f show than Madical Examinar must be inclifted at	d by	3 ☐ Widowed 4 ☐ Divorced Ÿ	ear or Dates:					
ب ک	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade com	pleted) (Gis	edent's Usual Occup re kind of work done o . DO NOT use retired	during most of wo	rking	16b. Kind of Business/	Industry
2	within lene. than "	ld m	Elementary/Secondary (0-12)	ollege (1-4or 5+) Mech		2)		merican Ca	n Co
7	filed with Hygiene thar thai		12 17. Father's Name (First, Middle, Last)	Mech	anic	18. Mother's Na	me (First, Middle, N		ii co.
land	e da fa	To Be	Antonio Morazzano				ana Donof		
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, P. Josephine Morazzano	1	iling Address (Street 6 Pinewood			City or Town, State, 2	Tip Code)
Baltimore,	Pages 1 and 2 nent of Health int: if itam 27 iny or other tra	1	20a. Method of Disposition 1		rematory or other place			20c. Location - City or	
Ę	tmen tant:		'4 □Donation 5 □ Other (Specify)	_ /	y Redeeme:			Balto.,Md	
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		6415 Rela	ir Rd .	Ralto Md	21206	Home, Inc.
г			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	is that caused the death. Do not e	inter the mode of dyin	ng, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Colon Cano		2 tastal			2 years
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		3451	100		0
	Examine	L	Sequentially list conditions, b	Due to (or as a consequence of):					
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence or).					
_	and and II-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence of):					
8760,	The law requires that the death certificate be executed we has been signed by the attending physician and page 2 should be detached for use as the burial-transit	calE							
687	ficate to physics the t	edlc		= 200					
×o	eath certific attending pl for use as f	N/W		yes, outcome of pregnancy				23d. Date of deli	ivery
ă	d for	Physiclan/M	in the past 12 months?	Pregnant at time of death	B □Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
P.0	t the de by the a	hys	9 ☐ Unknown 9	Unknown					
	es that igned to be det	by P	Part II. Dther significant conditions contribu	ting to death but not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob	pacco use contribute to	
ğ	w require been sig should b		CAD, Diabe	tis, Hyper	tension		1 □ Ye	es 2⊠No 3∏Pr	obably 4 Unknown
Vital Records,	e taw re has be ge 2 sho	Completed					24a. Was a		topsy findings available completion of cause of
Ä	The The sete has page	E O					perform	ned?/ death?	2 No
ita	ician: Th certificete rector, pag	Be	25. Was case referred to medicat examiner?			26. Place of De	ath (Check only on	Θ)	
of V	Physician: this certific ral director,	To	1 Tes 25 No Hospit	1 Inpatient 2 ENOutpat	IGIT 3 DOA	ner: 4 🗆 Nursing I	Home 5 Reside	ence 6 Other (Spec	cify)
			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year) 28b. Time	/ Woi		28d. Describe ho	w injury occurred	
Sio	Attanding r death. actor: After by the fune	cati	2 Accident investigation			Yes 2 No			
Division	2 = C	Certification:	4 Homicide determined	 e. Ptace of Injury - At home, farm, building, etc. (Specify) 	street, factory, office		City or Town	reet and Number or Ru n, State)	Irai Houte Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled it			n: To the best of my knowledge, de					
	ne Horna 7 24 h	Medical		On the basis of examination and/or and manner stated.	investigation, in my	opinion, death occ	urred at the time, d	ate and place, and due	to the cause(s)
	To the within To the comp	Ň	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Monta	h. Day, Year)
			* Kima Co	me mo	$\mathcal{L}_{\mathcal{O}}$	0469		2/6/0	4
,)	/		30. Name and address of person who comple	ted cause of death (Item 23a) (Typ	e, Print)		R	04:	-4261ECH
15			RIMA COUT		4940 Eas	stern H	ve, ba	KELMOR, 1	-17719774-
	Sta Regist	ate rar	AUG 0 9 2004	32. Registrar's Signature	no Kal				- 100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 Day Month a **Physician** NEWLON WILLIAM CLYDE 2004 10=384 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARford MEDICAL CENIER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Yrs. Months Days Hours Min. Mar. 5, 194 BEZAM UPPER CHEDAPETACE 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Director 213-44-8645 Illinois Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at MD Harford Abingdon Completed by Funeral Director 1 ☐ Yes 2 XNo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2952 Colchester Court 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ō 1 Yes 2 No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Salesman Towson Stationers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Earl Arthur Newlon Jean Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2952 Colchester Court; Abingdon, MD 21009 Health tem 27 Carol Lynne Newlon / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any Injury or once. 1 4 □ Donation Hilltop Service Corp! 8/10/04 Towson, MD 21. Signature of Fur mal Service Licens 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HADOUD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy Newlon, Wil 2/2 No 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1√Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital of within 24 hours at To the Funeral Completely filled it 29a. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 2004 DME 021809 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MUINOMIL 2 A S HU 2336 YORK US 32 Alegistrar's Signature State

Registrar

			1 - For State Registrar		ryland / Depa		ealth and M	lental Hygie	•	25027
	Physic /Medi		1. Decedent's Name (First, Middle, Last, MARCMER		RGINIA	NOA	KES	2. Date of Death Month	Day Year	3. Time of Death 1. 46 PM
7	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or L	ocation of Death		4c. County of Dea	th
			UPPER CHESAPEAKE 5. Social Security Number 6. Security Number			If Under 1 Year	If Under 24 Hrs.		HARF	
	Funeral Director		214-24-8849	л 25√7. Аде	(In yrs. last birthday) 77 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye July 10,	9. Bir 1927 Ma	thplace (State or Foreign ountry) aryland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Man Me-f sh	tor	Md. Harford	Į į	Forest H	ill				1 ☐ Yes 2 🔀 No
	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hygjene. It and Mental Hygjene. It is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Madical Examina in until or inviting a	Funeral Director	10e. Street and Number 3124 Grier Nurse	ery Rd.		10f. Zip Code 2105k	0	10g.	Citizen of What Co	puntry?
	ems 2	iner		12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of Hist f Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No-	14. Race - Ame	encan Indian,
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 □ Yes 2 🔯 N If Yes, Give	0		Specify:	riican, etc.)	Black, White	
21215-0036	2 hour	led k	15. Decedent's Edu	Year or Dates:	16a. Deced	dent's Usual Occupati	ion	168	. Kind of Business	hite
215	thin 7. e. en "n Med	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5-	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ring most of worki	ng		dada.ry
121	e filed with al Hygiene. I other then vent, the M		12		Cler				Insura	nce
Maryland	ould be fi Mental H tarked ot	To Be	17. Father's Name (First, Middle, Last) Henry Bates			1	18. Mother's Name Mary	(First, Middle, Mai Zito	den Sumame)	
ary	2 should and Meni ls marke	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ig Address (Street an			ty or Town, State, 2	Zip Code)
	C = 64 F		Ms. Mary Ernst/ Ni	ece	312	4 Grier Nu	ursery Ro			
Baltimore,	S = = 0		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R	emoval from State	I .	sition (Name of natory or other place)			. Location - City or	
Itin	permit. Page Department of Importent: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service License	H		Service Co	of Facility		Towson,	Md.
Ba	permit. Departr Importe any inji		· RALT	1		Ruck To	owson Fur	eral Home	Inc.	
Н			23a. Part1. Enter the disease, of complishock, or heart failure. List only or	cations that caused	the death. Do not ente	er the mode of dying,	such as cardiac o	r respiratory arrest,	1. 21204	Approximate Interval Between
	Physician	i n	Immediate Cause (Final disease or condition resulting in death)		4 MPHO	MA				Onset and Death
	/Medical Examiner		Toolahing in doubly	Due to (or as a	consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury	Due to (or as a	consequence of):					
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
,09	death certificate be executed e attending physician and id for use as the burial-transit	cai Ex	resulting in death) Last	Due to (or as a	consequence of);					
68760,	ificate g phys	edi								
Вох	death certifica attending ph I for use as t	M/us	230. Was decedent pregnant	3c. If yes, outcome o		Ectopic pregnancy			23d. Date of deli	very
	ne dea the att	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at t		Other (specify)			Month	Day Year
P.0	res that the de igned by the be detached	/Ph	Part II. Other significant conditions con	tributing to death but	not resulting in the ur	ideriving cause given	in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
rds,	law requires that the as been signed by th 2 should be detache	ed by	PLELRAL EF		4				2 □ No 3 □ Pr	- /
eco	e law requii has been s je 2 should	ompieted	FIRRO MYALS	14				24a. Was an	24b. Were au	topsy findings available
	The ate h page	Com						autopsy performed 1 ☐ Yes 2	? death?	completion of cause of 2 No
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othor	26. Place of Death			34 - 1900aan
of	ding Phys th. After this funeral dir	n: To	1 Yes 2 No	28a. Date of Injury	28b. Time of	28c, Injury a	t 2	ne 5 Residence		city)
ion	Attending r death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work? M 1 ☐ Ye	s 2 No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, stre (Specify)	eet, factory, office	2	8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying Phys	ician: To the best of	my knowledge, death	Occurred at the time	date and place	nd due to the carre	(c) and marcas	stated
	he Ho n 24 h he Fur sletely	edical	(Check only 2 Medical Examir one)	er: On the basis of e and manner state	examination and/or inv	estigation, in my opin	nion, death occurre	d at the time, date	and place, and due	to the cause(s)
	Tot Withi Total	ž	29b. Signature and title of certifier			29c. License n		29d.	Date signed (Month	n, Day, Year)
			· Uf- H		70	021	738	C	18/08	104
	5		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type, F	Print)	CEDICA	(CEN	TEX	Ter ALD
Γ	Sta Registr	te	31. Date filed (Manth Cay Year) 2004	32. Fegistrar		fre do.	,	00/0		000,11/2
	riegisti	211		1	121	proportion of				

04-5046 Katherir	Ame ne Obu	nd ns		38,12/6/04 TT Type or Print in Bla # 23a,2/1, per 1	ack Ind	elible lnk 5,9/09/(Ensure A	II Copies	Are Leg	gible.	
			For State Ragistrar	State of Maryland	Cert	ificate of t	leaith and i Death	nentai Hyg F	giene Reg. No.		25028
	Physici /Medic		1. Decedent's Name (First, Middle, Last	A. Obunse	ر			2. Date of Dea	Day	Year	3. Time of Death 2351 p M
	Examin		^{4a.} Facility Name (If not institution, give Shady Grove Adver	street and number)		4b. City, Town, or ROCK	Location of Death	L Augus	4c. Cour	004 ity of Death 1 t gome	
3	Funeral Director	6	5. Social Security Number 6. Se 103-68-02/7 Usual Residence of Decedent	x		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	54	9. Birth	place (State or Foreign ntry)
d 21215-0036 filled within 72 hours after death with the Maryland	Sa-f show	ctor	10a. State 10b. County German	utown Br	own or Loca	ntion)				1 ☐ Yes 2 No
ath with th	s 23a or 28 wat be no	ral Director	10e. Street and Number 19201 Til FORD	Way		10f. Zip Code	874		10g. Citizen o	What Cour	ntry?
036 urs after de	al, or items 23a or 28a-f show Examinational be notified al	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:		as Decedent of Hi es, specify Cubar Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	i	ace - Americack, White,	ean Indian, etc.
21215-0036 d within 72 hours aff	piene. r than "natural line Medical E	Completed	15. Decedent's Edu (Specify only highest grad	reation 1 e completed) College (1-4or 5+)	(Give kii	NOT use retired,	luring most of work)	ing	16b. Kind of	Business/In	dustry
<u> </u>	la de	Be	17. Father's Name (First, Middle, Last)	Jülius B. Jacks	son	Nur	Se 18. Mother's Name	e (First, Middle,	Maiden Suma	SPI 9	aL.
Mar	of Health and Ment f item 27 is marked r other traumatic e	To	19a. Informant's Name/Relationship (Ty	po. Prin(Husbard)	9b. Mailing	Address (Street a	nd Number or Run	al Route Number	r, City or Town	n, State, Zip	Code 20874
Baltimore,	nent of Hes int: If item iry or othe	i	20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	20b. Place	of Disposit	ion (Name of tory or other place CEME to		Date 1	20c. Location	- City or T	wn, State
Balti permit.	Department of Important: If any injury or once.		21. Signature of Funeral Service License	, Sumo		lame and Address	Fagility Con	e Fin	seral s	Serv	1212
	ysician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the death. Do no cause on each line. Chronic Al			such as cardiac o	or respiratory arm	est,		Approximate Interval Between Onset and Death
	Medical caminer	er	Sequentially list conditions,	Due to (or as a consequence). Due to (or as a consequence)							
O, executed	~ ∟	Examiner	cause. Enter Underlying Cause, Usease or injury that initiated events resulting in death) Last	Due to (or as a consequence							
c 6876 artificate be	attending physician for use as the buria	Medical	IF FEMALE:								
Division of Vital Records, P.O. Box 6876	the	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Onknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		topic pregnancy ther (specify)				ate of delive onth	ry Day Year
ords, P	been signed by should be detac	ed by Pł	Part II. Other significant conditions con	stributing to death but not resulting	g in the unde	orlying cause giver	n in Part I.		pacco use con		e cause of death?
al Reco	has Je 2	Completed						24a. Was ar autops perform	y	prior to con death?	psy findings available appletion of cause of
Vita	s certificate director, pag	o Be	25. Was case referred to medical examiner? ★ Yes 2 □ No	ospital: 1 ☐ Inpatient 2 ☐ ER/0	Sutpotions	Othor	26. Place of Death				
Sion of	⊊ ₩	H 1	27. Manner of Death 1 ♣Natural 5 ☐ Pending 2 ☐ Accident investigation		. Time of Injury	28c. Injury a	4 Nursing Hor	ne 5∐ Reside 28d. Describe ho)
DIVIS	by by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)				28f. Location (Str City or Town	, State)		
To the Hospital	within 24 hours after To the Funeral Dir completely filled in	Medical	one)	ician: To the best of my knowled her: On the basis of examination a and manner stated.	ge, death oc and/or invest	igation, in my opii	nion, death occurre	ed at the time, da	ite and place,	and due to	the cause(s)
• *	F 8		29b. Signature and title of certifier	•		29c. License i			od. Date signe August		
			30. Name and address of person who con AWA RUA 31. Date filed (Month, Day, Year)	310,40) (Type, Prir	111 Pen	n Street	, Baltin	nore, N	Maryla	and 21201
	Stat Registra		ANC 0 0 200A	32 Registrar's Signature	Spark	2					

DOS

			State of Marylar	•			Mental Hyg	giene			
		AMEND ITEM #4819a P	ER FH G834 8/	/23/ © PT	cate of	Death		Reg. No.	04,	25(129
-	Physician /Medical	1. Decedent's Name (First, Middle, Last	, ,	Overc	ash		2. Date of Dee	30	Year O4	73. Time of	5 PM
7	Examiner	4e Facility Neme (If not institution, give BALTIMORE VA ME		ten	4	ab City, Town, or	Location of Deeth	4c. County	of Death	<u>. </u>	
	Funeral Director	5. Spoig! Sequity Number 6. Se 1X 204-03-7235 Usuel Residence of Decedent	7. Age (In yrs. 81		Under 1 Year onths Days	If Under 24 Hrs Hours Min.		7. Year) 922	9. Birthpla Countr Penr	ice (State y) 1s1va	or Foreign .nia
	f show	10a. Stete 10b. County		ity, Town or Location					10	d. Inside C	City Limits
	Tect	10e. Street end Number			Of. Zip Code			10g. Citizen of V	What Countr	y?	
	Sa or	PO Box 457			2176	57		U.S.	Δ		
020	parmit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Haatih and Mentel Hygiens. Department of Haatih and Mentel Hygiens. Internetly, or items 23a or 28e-f show important: if tiems 27s in marked other than "haturely, or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1≿□ Yes 2 □ No If Yes, Give Yeer or Dates:				pecify Yes or No- to Rican, etc.)		e - America ck, White, e	tc.	
21215-0020	led within 72 holygiena. Nor than "nature N, the Medical is Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed) College (1-4or 5+)	16e. Decedent (Give kind life. DO	's Usual Occup I of work done VOT use retired	ation during most of word d)	rking	16b. Kind of Bu	usiness/Indu	stry	
7	ygien A th	12		Maintte	nance S	Superviso		Apt. Bu			
Maryland	should be filed and Mentel Hygi marked other umatic event, I	Charles Occasion of				Beulah	ne (First, Middle, Helman	Maiden Surnam	1e)		
Mar	alth and 27 is may traumy	19a. Informant's Name/Relationship (Ty					ural Route Numbe	- No. 10		>ode)	
a)	parmit. Peges 1 and 2 Department of Haalth Important: If Item 27 I any injury or other tr. once.	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. i	Place of Disposition commetery, cremator 1	n (Name of ny or other plac	(9)	11e, Mar Date	20c. Location -	City or Tow		
Baltii	parmit. F Departme importar any injur	21. Signature of Funeral Service License		22. Na	me and Addre	ss of Fecility Mi	ller/Dip Saltimore	pel Fur	neral	Home	Inc.
13	15.50	23a. Part 1. Enter the disease, or complishock, in heart failure. List only or	lications that caused the deat ne cause on each line.	th. Do not enter th	e mode of dyin	g, such as cardiad	or respiratory are	rest,		Approxima nterval Be	tween
4	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	. Metas	tatic	Panci	reatic	Cana	ır		Onset and	Death
	ig The second		or oud 2F1	or as a consequen 1 t 1 0 /	Papa	monie	λ				
	end end I-trens	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (d	or as a consequen					1		
8760,	requires that the death certificate be executed seen signed by the ettending physician end hould be datached for use as the burial-trensit eted by Physician/Medical Examiner	cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	c	or as a consequenc	ce of):						
Box 6	nding puse es	L ,	d								
œ œ	nat the death certiful do by the ettending latached for use e	Part II. Other significant conditions con	ntributing to death but not res	sulting in the under	lying cause giv	en in Part I.	23b. Did to	obecco use cor	ntribute to t	he cauee	of death?
, P.O	es that the death certific tigned by the ettending read datached for use es by Physician/Me						1 🗆 Y	'es 2□No	3 Probe	bly 4 🗔	Unknown
Records,	The law requires cata has been sig page 2 should b						24a. Was a perfor		avai	e autopsy lable prior pletion of eath?	to
	The law cata has by page 2 s						104	36 20 No	10	Yes 2	No.
Vital	sician: The certificata iractor, pag o Be Co	25. Was case referred to medical	Hospital:	ER/Outpatient 3	Oth	or.	ath <i>(Check only or</i> Iome 5□ Resid		as (Enneits)		
ou of	Attending Physician: r deeth. sctor: After this certific by the funeral director, iffication: To Be (27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injur		28d. Describe h				
Division	tal or Attending P rs eftar deeth. el Director: After t led in by tha funara Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h building, etc. (Special	ome, farm, street,	_		28f. Location (S City or Town	treet and Numb n, State)	er or Rural	Route Nun	nber,
_	To the Hospital or Attending Physician: The I within 24 hours effor death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	eiclan: To the best of my kno ner: On the basis of examina end manner stated.	owledge, death occ ation end/or investi	curred at the tin gation, in my o	ne, date and place pinion, death occu	, end due to the c irred at the time, d	ause(s) and ma late and place, a	inner as sta and due to t	ted. he cause(s)
	Within To the comp	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	d (Month, D	ay, Yeer)	
		1000	M.D.		VA PRO	V# 13-11	1382	7-30.	-04		
4		30. Name end eddress of person who co	empleted cause of death (Iter	n 23a) (Type, Print . / <i>0</i> /U	Chee.	ve StR.	1382 Peet BA	Ctimor	em!	2/0	20/
	State Registrar	31. Date filed (Month, Day, Year) AUG 0 9 2004	32. Registrer's Sign	Spece Spece	Ks						

DHMH 16 Rev 6/95

			For State Registrar	State of Maryland / Depa	artment of Health and N Tificate of Death	, ,	ne 004	25030
	Physici	an	1. Decedent's Name (First, Middle, La	st)		2. Date of Death Month	Day Year	3. Time of Death
1	/Medic	cal	Elizal		41.07. 7	August 4		5:20P M
	Examin	er	4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Death		4c. County of Death	• • • • • • • • • • • • • • • • • • • •
	Formul		3321 Pendleton D: 5. Social Security Number 6. S		Wheaton If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montgomer	ace (State or Foreign try)
	Funeral Director			□ M 2X F 83 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, You Jan 9, 19	921 Penr	nsylvania
	yland iow		10a. State 10b. County	10c. City, Town or Lo	cation		11	0d. Inside City Limits
	Mar e-1 st	io	Maryland Montgo	mery Whea	aton			1 □ Yes 2 🔀 No
	or 28	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun	try?
	ath w		3321 Pendleton D		20902		nited State	
	tame Itame	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?	Nas Decedent of Hispanic Origin? (Set Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	etc.
336	urs aft	by	3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I ☐ Yes 2 X No Specify:		Specify: Whi	te
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. of other than "natural", or Itame 23a or 28e-1 show event, I're Medical Examiner must be notilied at	Completed	15. Decedent's E (Specify only highest gra	ducation 16a. Dece	lent's Usual Occupation kind of work done during most of won	king 16	b. Kind of Business/Inc	lustry
21	ithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	OO NOT use retired)		. 1. 1 D	
22	S should be filed withir and Mental Hygiene. Is marked other than eumatic event, It's Marken		12 17. Father's Name (First, Middle, Last		chboard Operator	ne (First, Middle, Mai	Medical Bur	reau
and	ntal h	Be			Lillian		den damame)	
Z	should be fand Mental I s marked o	2	Joseph Francis Lo		g Address (Street and Number or Ru		itv or Town. State. Zip	Code)
	# 27 = 1d		Rebecca Galleriz		Silver Rock Road;			
ē,	ges 1 and 2 t of Heelth if item 27 or other tr	1	20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)	the second secon	c. Location - City or To	
E C	Page nent o int: If		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Memoval from State	ark Crematory 08/	09/2004 F	Baltimore,	MD
Baltimore,	permit. Pages 'Depertment of H Importent: If Ite any injury or ot		21. Signature of Funeral Service Licer		Name and Address of Facility Lmple Tribute Fundament			
	2012		Milling S.	Dr Wile 2 10)40 Rockville Pik	e; Rockvil	lle, MD 208	352
П				plications that caused the death. Do not ent one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician	4 0	Immediate Cause (Final disease or condition resulting in death)	a. Chronic Lymphocy	ic Leukemia			
	/Medical Examiner			Due to (or as a consequence of):				
ŧ.		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0				
o,	an an	Exa	resulting in death) Last	Due to (or as a consequence of):				
68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	edicai		d				
	Se as		IF FEMALE:	23c. If yes, outcome of pregnancy		-	004 Date of dalling	
Вох	eath cert attending for use a	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal death 3 □	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
P.O.	that the de ted by the a detached	Physician/M	1 ☐ Yes 2 █ X No 9 ☐ Unknown	9□ Unknown				
	res that igned b	by P	Part II. Other significant conditions	contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
Vital Records,	w require been sig should b	ed k				1 Tes	2 X No 3☐ Proba	abiy 4 □Unknown
ecc	e law re has be je 2 sho	Completed				24a. Was an autopsy	24b. Were autop	sy findings available
<u>س</u>	The ate h page	PO.				performed 1 ☐ Yes 2 🔀	d? death?	
/ita	certificate harector, page	Be	25. Was case referred to medical examiner?			th (Check only one)		
of	Physi this c	2	1 ☐ Yes 2 🛱 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. Date of Injury 28b. Time of			e 6 Other (Specify)
no	ding P th. After funera	tion	1 XNatural 5 ☐ Pending	(Month, Day Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Atten deat octor: y the	fica	3 Suicide 6 Could not b	28e. Place of Injury - At home, farm, str			et and Number or Rural	Route Number,
Ö	s effe	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S	state)	
	To the Hospital or Attending Pi within 24 hours efter death. To the Funerel Director: After t completely filled in by the funera		29a. Certifier 1 Certifying Pl	nysician: To the best of my knowledge, death	occurred at the time, date and place	, and due to the caus	se(s) and manner as sta	ated.
	the H In 24 the F	Medicai	one)	and manner stated.				
	T WITH CO	2	29b. Signature and title of certifier	CAT MC	29c. License number		. Date signed (Month, L	
	20		yorke of	to THO USARMY	VA0101236543		August 6, 2	
	αU		Joshua D. Hartze	completed cause of death (Item 23a) (Type, 11. MD) Walter Reed	Army Medical Cent		Georgia Ave	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature		,	-U, 20 2	
	Registr	ar	AUG 0 9 20	14 Benna G				
DH	MH 17 Rev 1/2	001		/	sparks			
				ORIGINA	\L			

ELIZABETH RUTH PIERCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend item | State | # 20b-c, per FH, G834, 8/23/05e Whicate of Death 1. Decedent's Name (First, Midelle, Last) 2. Date of Death **Physician** August 06, 2004 ar 0156 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital, Shock Trauma Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth May Ye. 5. Social Security Number 220 · 04 · 1283 6. Sex 9. Birthplace (State or Foreign **Funeral** Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov other treumatic event, the Medical Examiner must be notified at MD HAUTIMORE 1. Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a by Funeral 14. Race - American Indian 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No BLACK 3 Widowed 4 Divorced neturel', Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

ABOLECK 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumam KOSALIND 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 ie FATHER TERRACE 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pikesville 20b. Place of Disposition (Name of Drunk) Riabor Can ō <u>=</u> permit. Page Department of Importent: If any injury or once. Cournelle, * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAVCHIN C. GREENE FUNELAL Home 21. Signature of Funeral Service ORK ROAD BALTO, NO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a donsequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Cl Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of eath: Yes 2 No 1 Yes 2□No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' Other: 1 XYes 2 No 1 Inpatient 2X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of Injury (Month, Day) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 01:29M within 24 hours after death. To the Funerel Director: A -6-04 investigation 2 Accident 6 Could not be determined Location (Street and Num. City of Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) (Street and Number or Rural Route Number, Homicide Sider 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) O.C.M.E. August 06 ,2004

Registrar

ne and address of person who completed ca

111 Penn Street, Baltimore, Maryland 21201

of death (Item 23a) (Type, Print)

OLIAK 32. Registrar's Signature

Physici		Stata Registrar # 23a,27	Last)				2. Date of De	Reg. No. U	3. Time of De
/Media		BENJAMIN	TAI	D	RIC		AUGUST		004 0438 A
Examir	ner	4a. Facility Name (If not institution, Q HOLY CROSS HOSP)	•			or Location of D SPRING	eath	4c. County MONTG	
Funeral			. Sex 7. Age	(In yrs. last birthda		r If Under 24	Hrs. 8. Date of Birt (Month, Da		9. Birthplace (State or Fo
Director		255-399251 Usual Residence of Decedent	X M 2 F	24 Yrs.	World S Days	riouis in	12/07/1	979	GA.
MO M		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City L
or 28a-f show	ctor	S.C. CHARL	ESTON	CHARLES	TON				X¹ □Yes 2[
or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Country?
18 23a	eral	825 DUCK HAWK RE		una in 11 C	29412		2/0	U.S.A.	
ene. than "natural", or Itams 23a or 28a-f show the Medical Exame not must be to diffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Example Forces? 1		If Yes, specify Cui	ban, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)		e - American Indian, ck, White, etc.
"natural", edical Ex		15. Decedent's	Education	16a. De	edent's Usual Occu	ıpation		16b. Kind of Bu	usiness/Industry
ene. than "r	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5+	·)	re kind of work done . DO NOT use retire	e during most of ed)	working		
Hygier thar th nt, th	Cor	12 17. Father's Name (First, Middle, La	et)	C00k		40.44-21.4.1		RESTAURA	
Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or Itams 23a or 28a-f shoi any injury or othar traumatic evant, I'm Medical Examinatinust be inditied at once.	To Be	ARTHUR P 19a. Informant's Name/Relationship		RICHEK		NANCY	Name (First, Middle,		COHEN
Ith an 27 Is r traur		ARTHUR P. RICHE	, ,,,,,,				T CHARLES		
f Healitem		20a. Method of Disposition	K / TATILI	20b. Place of Dis	position (Name of		Date	20c Location	City of Town State
nent o ant: If ary or		1 ☐ Burial X ☐ Cremation 3 ☐ Other (Special Control of	Removal from State	HILLTÖP	SERVICE C	0RP. 08	/6/2004	ΓOWSON,	MD
Departn Importe any inju		21. Signature of Funeral Service Lic	9500	> 8	22. Name and Addr	ess of FacilityS	OL LEVINSO ROAD - PI	ON & BRO	OS., INC. E, MD 21208
*		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the						Approximate Interval Betwee
ysician :		Immediate Cause (Final disease or condition		Intoxic					Onset and Deal
Medical xaminer		resulting in death)	- u	consequence of):					
4-	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
d ansit	Examiner	cause. Enter Underlying Cause (21s assert in 197) that initiated events							-
ian an ırial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):					
physician and the burial-transit	dicai		d						
ding p se as		IF FEMALE:	23c. If yes, outcome of	f pregnancy					
r this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti	Fetal death	☐Ectopic pregnand☐Other (specify)	СУ		23d. Dat Mor	e of delivery nth Day Year
by the tached	hysi	9 Unknown	9□ Unknown						
igned be del	by P	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	ven in Part I.	23e. Did to	bacco use contr	ribute to the cause of death
been si should	ted						1 Y	es 2 🗆 No	3 Probably 4 Unkr
has b	Completed						24a. Was a autops	an 24b. V	Vere autopsy findings availarior to completion of cause
certificate ha rector, page		DE Maria and and an artist of the second sec			_		perfor 1 Yes	med? 0 2 □ No 1	leath? Yes 2□ No
is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 XER/Outpati	ent 3 DOA Ot		Death Check only or	-	
After thi		27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time	of 28c. Inju		g Home 5 Resid		
r death. actor: After by the fune	atic	1 □Natural 5 □ Pending 2 □ Accident investigati	on 8/4/04			Yes 2 XNo	Unknown		
Diract Diract in by	Certification:	3 ☐ Suicide 6 ♣ Could not determine	building, etc.	y - At home, farm, : (Specify)	treet, factory, office		City or Town	n. State)	er or Rural Route Number,
Funeral I	edical Ce	(Check only ZY Medical Ex	Physician: To the best of aminer: On the basis of e	xamination and/or	ith occurred at the t	ime, date and pla	ace and due to the c	George	Hill Road Ap S County, M nner as stated. Ind due to the cause(s)
- a 0		29b. Signature and title of certifier	and manner state	PG.	29c. Licen				(Month, Day, Year)
o tha			11/1						
withir To th comp			// // 5/	_		() ('. IVI H.	/	711(*11/~11. ~	5 2004
withir To th comp	1	30. Name and address of person who	completed cause if dia	th (Item 23a) (Type		O.C.M.E	•	AUGUST 5	5,2004

				For State		State	of Marylar	-	artment of				-	201	0 170 0	
				Registrar 1. Decedent's Name (/	irst. Middle.	Last)			incate of	Dea	u i	2. Date of De	Reg. No.	بللل	3. Time of 1	Death
		Physici	an		riella		110					Month	Day	200		
4	*	/Medic Examin		4a. Facility Name (If no					4b. City, Town,	or Locati	on of Death	July	4c. 0	County of De		
	1		ei	Shady Grov					Rock			•		ntgom		
		Funeral		5. Social Security Num		. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Un	der 24 Hrs.	8. Date of Bi (Month, Da		9. B	irtholace (State or	Foreign
	п	Director		None		1 □ M 2 🔯 F	() Yrs.	Months Day	Hou 1	rs Min.	July 1	ay, Year) . • 2004	Ma	country) ryland	
		D.		Usual Residence of De												
		nylar how	_	10a. State	0b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City	
		Sa-f e	cto	Maryland	Freder	ick		Freder	ick						1 □ Yes	X
		ith th	Director	10e. Street and Number	er				10f. Zip Code				10g. Citiz	en of What	Country?	
12		deeth with the Maryland me 23s or 28s-f ehow finited by facilitied at		7216 Black	Creek				2170					ed St		
4		er de	Funeral	11. Marital Status		Armed F		J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic ban, Mex	: Origin? (Specican, Puerto	ecify Yes or No Rican, etc.)	0- 1-	4. Race - Ar Black, Wi	nerican Indian, nite, etc.	
ž	36	hours efter turei', or ite al Exemina	by F	1 Never Married 3 □ Widowed 4 [d l∐Yes If Yes, G Year or	217 No ive		1□Yes 2XIN	Spec	city:			Specify: W	hite	
3	21215-0036	n 72 hours efter deeth with the Marylar "naturel", or Iteme 23e or 28e-1 ehow edical Examinat he multied at	ed		. Decedent's		J4(63.	16a Dece	dent's Usual Occ	upation	-		16b Kin	d of Busines	ss/Industry	
4	15	filed within 72 Hygiene. Ither then "nai	Completed	(Specify	only highest	grade completed		(Give	kind of work don DO NOT use retii	e during r ed)	most of work	ing	100. 1411	0 0 00000	Samuel Sury	
)	212	I withir	E	Elementary/Seconda	ary (0-12)	College	(1-4or 5+)	Non	e				Nor	ıe .		
3	פַ	be filed within tal Hygiene. dother then event, the M	Be C	17. Father's Name (Fir	st, Middle, La	ist)				18. M	other's Name	First, Middle	, Maiden S	Sumame)		
2	<u>a</u>	should be nd Menta marked matic ev	To B	Marco Scar	zella					An	ny Cad	е				
7	Maryland	2 should be f and Mental I ie marked or raumatic eve		19a. Informant's Name	Relationship	(Type, Print)		19b. Mailir	ng Address (Street	et and Nu	mber or Rura	al Route Numb	er, City or	Town, State	, Zip Code)	
1		es 1 and 2 should b of Heelth and Ment I item 27 ie marked r other traumatic e		Amy M. Sca	rzella	/Mother			Black C		Lane;	Freder	ick,	MD 21	703	
5	ore	of He roth		20a. Method of Dispos 1 ☐ Burial 2 🕅 0		□Removal from	20b.	Place of Dispo cemetery, crea	sition (Name of matory or other p	ace)		Date	20c. Loc	ation - City	or Town, State	
+	Ĕ	Peg ment ant: I		`4 □Donation 5				. Linco	1n Crem	atory	08/0	5/2004	Brei	ntwood	, MD	
40	Baltimore,	permit. Peges Depertment of I Important: If It any injury or of		21. Signature of Fune	al Service Lic	ensee O T	1/	SI	Mame and Add	ess of Fa	e Fune:	ral and	Crem	ation	Center	
Sa	_	₹ 0 = 3		Cen	my	Son	2	10	40 Rock	ille	Pike	; Rockv	ville,	MD 2	0852	
				23a. Part1. Enter the shock, or heart for	allure. List or	omplications that nly one cause on	caused the dea each line.	th. Do not ent	er the mode of dy	ring, such	as cardiac o	or respiratory a	ırrest,		Approximate Interval Betw Onset and De	een
		Physician		Immediate Cause (Fir disease or condition	nal	-a. Ext	Jeme K	enatu	irdy						1110	oan
		/Medical Examiner		resulting in death)	- 1	Due to	(or as a conse	1.	0 (,	
		- Adminion		Sequentially list condi	tions.	b	(or as a consec	A	yps plase	a					14× 20	din
		led Islt	Examiner	Sequentially list condi- if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ng 4	P	ou de	Cervi	'C							
		xecu and	xar	that initiated events resulting in death) Las		c	(or as a consec	quence of):	0						1 hx 20	and a
	8760,	cete be executed physiclen and the burial-transit	dical E			, t	ty poper	son ,	1 Shock	•					1 las 20	u.
	89	ificete g phys es the	edic			0		1								
	Вох	nding use	M	IF FEMALE: 23b. Wes decedent pr	egnant	23c. If yes, or	utcome of pregn		Te				23	d. Date of d	lelivery	
	m.	death e ette d for	Cla	in the past 12 mo 1 ☐ Yes 2 ☐ N	onths?	4□Preg	birth 2 Feta nant at time of the		Ectopic pregnan Other (specify)	cy 				Month	Day Ye	ear
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		The law requires that the death certificate has been signed by the ettending to age 2 should be deteched for use as		Part II. Other significa	Ou .		death but not res	sulting in the u	nderlying cause g	iven in Pa	art I.	23e. Did	tobacco us	e contribute	to the cause of de	
	ord	equir sen si ould	Completed by	neun	roller	VX						10	Yes 2	No 3□	Probably 4 Nur	known
	ecc	es co co	ple									24a. Was		24b. Were	autopsy findings av	vailable
	E	sicien: The law certificete has b irector, page 2 s	PO.									perfe 1 ☐ Yes	2 No	death'	? es 2□ No	
	/ita	clen: ertific	Be	25. Was case reterred examiner?	to medical						lace of Death	(Check only	one)			
	of	Physi this c	ဥ	1 Yes 2 No		1	1	ER/Outpatier	11 3 DOV			me 5 ☐ Resi			pecify)	
	Ľ.	ling F	lo		5 Pending		nth, Day Year)	28b. Time of Injury	W			28d. Describe	how injury	occurred		
	isic	death death stor: / the	Icat	2 ☐ Accident 3 ☐ Suicide	investigat 6 □ Could not	t be 280 Place	e of Injury - At h	nome farm str	eet, factory, office]Yes 2		28f Location /	Street and	Number or	Rural Route Numbe	nr.
	Division of Vital Records,	l or A efter Direction by	Certification;	4 Homicide	determine	build build	ling, etc. (Speci	fy)	eer, raciory, onice	,		City or To		realinger of t	TOTAL FROM TO THE	or,
	_	spite tours nerel		29a Certifier	Certifying	Physician: To th	e best of my kn	owledge, death	n occurred at the	time, date	and place,	and due to the	cause(s) a	nd manner	as stated.	
		ne Ho ne Fu netely	edical	(Check only 2[one)	☐ Medical Ex	teminer: On the	basis of examination of the state of the sta	ation and/or in	vestigation, in my	opinion,	death occurr	ed at the time,	date and p	place, and di	ue to the cause(s)	
		To the Hospitel or Attending Physicien: The i within 24 hours effer death. To the Funerel Director: After this certificete ha completely filled in by the funeral director, page.	ž	29b. Signature and title	e of certifier		111)	29c. Licer		er		29d. Date	signed (Mo	nth, Day, Year)	
				> //la	al	y	1000		43	22 5)		Jul	4 12	007	
		1		30. Name and address	of person wh	no completed cau				0 - 14	Ro	kinte	A . A	7-01)	
				MOHU	NIGA	un sh	-		wentist f	(05/1.	1	or nece o	W. 0	10850		
		Sta Registr		31. Date filed (Month,	9 200	1 Jus	Registrar's Sign	ature ,	Sporks	•						

Physicia		1. Decedent's Name (First, Middle, La	ast)				2. Date of D	eath Day	Year	3. Time of Death
/Medica		Veronica	Cec	ilia		Smith	Auss	3 7	400	10:56 A
Examine	" 1	4a. Facility Name (If not institution, given	ve street and number)			wn, or Location of Dea	ath	4c. Count	y of Death	
		Sinai Hospital a	of Balkmore	yrs. last birthda		marc City Year If Under 24 Hi	S 9 Date of B	idh	a Rirtho	lace (State or Forei
Funeral Director		, , , , , , , , , , , , , , , , , , , ,	Sex 7. Age (In 1			Days Hours Mi	n. (Month, L)ay, Year) 14 23	Coun	md
		146-18-5629 Usual Residence of Decedent						L4 20		
show	- 1	10a. State 10b. County	10	c. City, Town or					['	Od. Inside City Limit 1 XYes 2 □ N
8a-f	Director	MD NA		Baltim	10f. Zip C	ode		10g. Citizen of	What Cour	
Bor 2		10e. Street and Number	and Ct Ar	s+ 2Λ	101. ZIP C	21216			.S.A.	•
permit. Tages 1 and 2 should be little within 72 hours are used want with the maryana. Department of Health and Mehrlal hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiliar interpretable building all once.	Funeral	2411 St. Steph	12. Was Decedent Eve	r in U.S. 13	3. Was Deceder	nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes or N	No- 14. Ra	ce - Americ	
or Ita	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes \$1500 No If Yes, Give		1 ☐ Yes 25		etto micari, etc.)	Speci	ack, White,	
Fig.	d b	XXVidowed 4 □ Divorced	Year or Dates:						BJ	lack
"natt	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	(Gi	cedent's Usual ve kind of work b. DO NOT use	done during most of w	vorking	16b. Kind of E	dusiness/in	dustry
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Hygi ont, I		17. Father's Name (First, Middle, Las				18. Mother's N	lame (First, Midd	le, Maiden Suma	me)	
kad c	To Be	Cornelius Samu	els			Veron	tea Sam	uels-		
s ma		19a. Informant's Name/Relationship	(Type, Print)			Street and Number or				
n 27 in ear tre		Harry Stanton				Cold Spi	cing La	ne, Ba.		
of He If iter		20a. Method of Disposition XXBurial 2 ☐ Cremation 3	DRamoual from State		rematory or oth	er place)				
tment tant: jury		*4 □ Donation 5 □ Other (Spec	city)	Garris		est Vet. Address of Facility	8/10/0	4 Owin	gs Mi	IIIs, Mc
Depar Impor any in		21. Signatura Huneral Service Lic	ensee AKII	nH 1	March	F/H West	n 1.	•	M.J	21215
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		shock, or heart failure. List on	ly one cause on each line.							Onset and Death
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aminer		resulting in death)	Due to (or as a c	onsequence of):	Embolis	M				3 days
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Skudy Robert 11:20a[™] August 05 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Oak Crest Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1X M 2 F 79 148-24-7852 1925 Director Lithúania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ir then "natural", or items 23a or 28a-f shov If a Medical Expedient must be notified at Baltimore Baltimore 1 ☐ Yes 2 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2912 Aspen Hill Rd. 21234 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other then " Elementary/Secondary (0-12) College (1-4or 5+) Treasury Patent Dept. other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H Is marked of Skudzinskas Adolphina Slabosevicius Petras 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 t of Health : Mr. Algirdas Skudzinskas 2912 Aspen Hill Rd. Baltimore, Md. 21234 Iltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ŏ permit, Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 8-7-04 lowson, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, 21. Signature of Fureral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21204 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) encephalopath anotic Physician /Medical Due to (or as a consequence of) Examiner STOKE Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and the burial-transit death certificate be executed Due to (or as a consequence of) Physician/Medical attending ph for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. signed I Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 10 2 No 1 Yes 1 TYes Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 2 1 Yes 4 ursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this After th 28c. Injury at Work? 27. Mann Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 0 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatore and title of certifie 29c. License fumber 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause ordeath (Item 23a) (Type, Print) The Series 0+1 7800 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 9 2004 Registrar

112	A STE	ME	For 1_ State	Please				/ Depa	delible In artment of	Healt	h and M		giene	9		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Phyllis Ann Steimel							tificate of Death 2. Date of Death Month AUGUST				.004	3. Time-of Death 4:50 P M	
*	Examin								4b. City, Town, or Location of Death WESTMINSTER					4c. County of Death CARROLL CO		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 D M 2 F 7. Age (In yrs. last birthday) 5. Social Security Number 1 D M 2 F 5. Social Security Number 6. Sex 1 Months Days Hours Min. Months Days Hours Min. March 3, 1947 Maryland												thplace (State or Foreign ountry) ryland	
Maryland 21215-0036	ages 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Executer man be notified at	rector	Usual Residence of 10a. State		10c. City, Town or Location			cation	ation					10d. Inside City Limits		
			Maryland 10e. Street and Nur		Westminster 10f. Zip Code							10g. Cit	1 ☐ Yes 2 ☑ No			
		ral Di	3319 Ma										United States			
		by Funeral Director	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	Ame 1 🗆 Y If Yes	Yes 2. XNo			Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:				0-	14. Race - American Indian, Black, White, etc. Specify: White			
		Completed	(Specify only highest grade completed) (Give kir						ent's Usual Occupation 16b. K kind of work done during most of working NO NOT use retired)					Kind of Business/Industry		
		Comp	Elementary/Seco		ege (1-4or 5+)			chologis			Radiological					
and		Be	17. Father's Name (First, Middle, Last) Edward Richard Brueck							18. Mother's Name (First, Middle, Maide Catherine Marion					-	
ary le		To												or Town, State,	Zip Code)	
				Steimel	I	Husba		3319			7	minste	_			
Jore				☑Cremation 3 □		rom State			sition (Name of natory or other p		1	Date		ocation - City or		
Baltimore,	permit. Pages 'Department of H Importent: If ite eny injury or ot			5 ☐ Other (Specify Ineral Service bice)		Uly	Sout	22 B1	2. Name and Add	dress of F	acility Funer	al Home	e & (Cremato	ry, P.A. MD 21784	
	Physician /Medical Examiner	(23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	he disease, or com nt failure. List only (Final n	a	Co	the death. ne. ntact a conseque	Gun	er the mode of o			,	ırrest,		Approximate Interval Between Onset and Death	
ion of Vital Records, P.O. Box 68760,	or Attending Physicien: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):													
		Physician/Medic								Ectopic pregnancy Other (specify)				23d. Date of delivery Month Day Year		
		by	Part II. Other significant conditions contributing to death but not resulting in the under							nderlying cause given in Part I. 23e. Did tobac				cco use contribute to the cause of death? 2 🕱 No 3 🗆 Probably 4 🗀 Unknown		
		Completed								24a. Was an autopsy performed						
		o Be	25. Was case rele examiner? 1 X Yes 2		Hospital:	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA					26. Place of Death (Check only one) 1. 4□ Nursing Home 5□ Residence 6 □ ther (Specify) SCENE				CONT.	
		atlon; To	27. Manner of Dear		28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?					1.0	28d. Describe how injury occurred Subject Shot Setf					
Division		Certification;	3 ⊠ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, streen building, etc. (Specify)						281. Location (Street and Number or Rural Route Nu. City or Town, State) 3319 Mail Rd. Westminste					
	To the Hospitel within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one)	ledge, deat on and/or in	h occurred at the vestigation, in m	occurred at the time, date and place, and due to the cause estigation, in my opinion, death occurred at the time, date a					s stated.					
	To th withir To th	Me	29b. Signature and title of certifier											Date signed (Month, Day, Year)		
•	.0	1	+ Lamote Townall, MD.							OCME AUGUST 6,					0, 2004	
	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin						111	Penn	Stree	t, Bal	timo	re, Mary	yland 21201	
	Sta Regist		31. Date liled (Mor	nth, Day, Year)	4	32 Registr	rar's Signatu	lire L	Spark	1						

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death 021 AM GABERT Physician /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Long Green Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Months Days Hours Yrs. Director 89 ΫA 217-09-9030 Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ie filed within 72 hours aftar death with the Marylar at Hygiene.
It Hygiene is to the season 23e or 23e-f show to the transmission of the season 23e-f show went, it is Medical Examiner must be notified at iX Yes 2 □ No Director Baltimore NA MD 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21215 5102 Chalgrove Ave 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes XIXNo Specify: Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Contracter Cement Worker 6th grade na traumatic event, 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filment of Health and Mental Heart: If item 27 is marked off Sophia Nickens Richard Spence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 21215 5102 Chalgrove Ave, Baltimore, Md Reese C Spence-Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of important: If it any injury or o Nation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 8/6/04 Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Sign that of Funeral Service License, 4300 Wabash Ave, Baltimore, Md 21215 R Tart1. Inter the disease, or com, half-ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Athero scleratic cardiovasola Uslace Examiner Due to (or as a consequence of) Examine Dehydration The law requires that the death certificate be executed attanding physician and for use as the bunal-tran Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760 Sacral Physician/Medicai Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Ö 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ø Unknown ۵ achexia þ Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed certificate has director, page 2 1 Yes 2 4 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Yeer) 29b. Signature end title of certifler 29c. License number 814/07 10059056 WD

State

Registrar

DHMH 16 Rev 6/95

1600 W MT

32. Registrar's Signature

But MD 21217

30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

Saloya

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31. Dete filed (Month Pay G ear) 9 2004

MD

			1 - For State Registrar	State of Maryland / Dep	partment of Healt ertificate of Dea			ne 2004	25038
ł	Physici /Medio		1. Decedent's Name (First, Middle, Las	SNEAD		0	lugist =	Day Year 200	
) 	Examin Funeral Director	er	4a. Facility Name (If not institution, give	al of Baltimore	y) If Under 1 Year If Un	nder 24 Hrs. 8	Date of Birth (Month, Day, Yea	4c. County of Dea	nthplace (State or Foreign ountry)
	D	_	217-22-6583 Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			05 30	25	10d. Inside City Limits
	with the Ma or 28e-f s	Director	MD NA 10e. Street and Number	Baltim	10f. Zip Code		10g.	Citizen of What C	1 X Yes 2 □ No country?
036	be filed within 72 hours after death with the Maryland lat Hyglene. d other then "netural", or items 23e or 28e-1 show event, the Medical Exerting Frust be hydlied at	by Funeral	11.00 Pennsylvar 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	nia Ave Apt 914 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 MNo If Yes, Give Year or Dates:	2120] 3. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2X No Specific No Sp	c Origin? (Speci xican, Puerto Ri	ify Yes or No- can, etc.)	U.S.A 14. Race - Am Black, Wh Specify:	erican Indian,
21215-0036	filed within 72 ho Hygiene. other then "neturi ent, I's Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 7th grade	de completed) (Gi life College (1-4or 5+)	cedent's Usual Occupation we kind of work done during to DO NOT use retired) Omestic Work	most of working	16b.	Kind of Business	s/Industry
Maryland	should be file and Mental Hy s marked oth umetic event	To Be	17. Father's Name (First, Middle, Last) Norman Snead 19a. Informant's Name/Relationship (7)	Type, Print) 19b. Ma		nnie D			Zip Code)
altimore, Ma	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 is marke eny injury or other treumetic <u>once</u> .		Rose Moulton-Da 20a. Method of Disposition 1 Burial 2 Cremation 3 Cremation 5 Other (Specify	Removal from State 20b. Place of Discemetery, completely, compl	6 Division position (Name of rematory or other place) emorial Par	Street rk 8/1	t Balt	imore. Location - City o	Md 21217 r Town, State
Ba	Depa Impor		21. Signature of Funeral Service Licen	B. Keke !	22. Name and Ad tess of F arch F/H We 300 Wabash	Ave,		re, Mđ	21215
	Physician /Medical Examiner		sho k, or heart aure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	MONARY GM				Approximate Interval Between Onset and Death (W. W. of) (ATE
í		Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b					
68760,		edlcal		d					L_
P.O. Box (The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of de Month	elivery Day Year
	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in P	Part I.		4	to the cause of death? Probably 4 □Unknown
al Records,		Completed					24a. Was an autopsy performed 1 Yes 2 🔀	? prior to death?	autopsy findings available completion of cause of s
Division of Vital	tending Physicath. tor: After this the funeral di	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		of 28c. Injury at Work? M 1 Yes	Nursing Home 28 2 \(\text{No} \)	Check only one) 5 Residence d. Describe how in	njury occurred	ecify) Bural Route Number,
<u>></u>	spitel or Attendous after death		4 ☐ Homicide determined 29a. Certifier 1 ☑ Certifying Ph	building, etc. (Specify) ysician: To the best of my knowledge, de	eath occurred at the time, dat	te and place, an	City or Town, St	ate)	s stated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of examination and/or and manner stated.	investigation, in my opinion,	, death occurred ber	d at the time, date a	and place, and du Date signed (Mor	ne to the cause(s)
•	3			completed cause of death (Item 23a) (Type UUFS), up 240/					5, 2004
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1.	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. Ng. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 2004 tuaust /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** ba Baltimore more Damaritan 5 If Under 24 Hrs. If Under 1 7. Age (In yrs. last birthday) 8. Date of Birth DEC 27, 1928 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 25 F 75 Yrs. Director 135-22-3277 GA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ral', or Items 23e or 28e-f show Examiner must be notified at 1X Yes 2 □ No Directo MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 1640 WINFORD ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married AFRICAN Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: AMERICAN þ 3 Widowed 4 Divorced ed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Complet Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT 12th KEYPUNCH OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WESLEY B. ZACHARY ANNIE K. ZACHARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAMAR SMITH (SPOUSE) 1640 WINFORD ROAD BALTIMORE, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FOREST VET. CEM AUG. 13, 2004 OWINGS MILLS, MD 21. Signature of Puneral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 2 a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myorardial disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by rend 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has page 2 1 Yes 2 No Fo the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 20ER/Outpatient Yes 2□No P 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

(0000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - 5

ere ic 31. Date filed (Month, Day, Year)

AUG 0 9 2004

N0059540

SAMARITAN

	_1	State Registrar	tate of Maryland / (Department of H Certificate of L	Death	Reg. No	2001	25040
Physician /Medica Examine	1	Decedent's Name (First, Middle, Last) 1ERRY S+ a. Facility Name (If of institution, give street)	ansbury et and number)	4b. City, Town, or		pate of Death Month Da	Year POSH County of Death	3. Time of Death 6:30 pt
Funeral Director		403 PLAZA COURT Social Security Number 6. Sex	APT 2A 7. Age (In yrs. last bit	ABERDE thday) If Under 1 Year Months Days	If Under 24 Hrs. 8. 1 Hours Min.	Date of Birth Month, Day, Year,	Coul	place (State or Foreign ntry) YLAND
yland		Jsual Residence of Decedent Oa. State 10b. County MARYLAND HARFORD	10c. City, Tow	n or Location ERDEEN			1-1	10d. Inside City Limits 1 ☐ Yes 2XXNo
6 after death with the Mar or items 23s or 28s-1 or orner must be multified	leral Direc	0e. Street and Number 403 PLAZA COURT	APT 2A Was Decedent Ever in U.S.	10f. Zip Code 210	0 0 1 lispanic Origin? (Specify an, Mexican, Puerto Rica		U.S.A.	can Indian,
1215-0036 within 72 hours after ene. than "natural", or itel the Maulical Exercities	2	12 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educati	Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Black, White, Specify: BL Kind of Business/Ir	ACK
nd 21215 illed within 72 I Hygiene. other than "ne	Completed	(Specify only highest grade co	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired				L CONTRACTO
larylar 2 should be and Menta ie marked aumatic ev	0 20	N/A 19a. Informant's Name/Relationship <i>(Type,</i>		o. Mailing Address (Street	ETHEL and Number or Rural Ro	M STANSE	URY or Town, State, Zi	252
or Heal		Claudell R. Taylor/ 20a. Method of Disposition 1 🖫 Burial 2 □ Cremation 3 □ Rem 1 □ Done on 5 □ Other (Specify)	20b. Place of cemeter oval from State	44 Concord F of Disposition (Name of any, crematory or other place U.M.C. CEME	Date	20c. L	ocation - City or T	
Baltime permit. Pag Department important: It any injury o		21. Signal re of Funeral Service Site ree 23a.Par1. Enter the disease, or complicat	ions that caused the death. Do	22. Name and Addre WM C BROWN 321 S PHII	ss of Facility I COMMUNITY ADELPHIA BI	FUNERAL VD., ABF	HOME-HAR	FORD, P.A.
Physician /Medical Examiner		shock, or heart failure. List only one of instance of the condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	Carair	omo of	-	youe	Interval Between Onset and Death
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Vision of Vital Records, P.O. Box 68 Attanding Physician: The law requires that the death certifica reach: Actor: Affer this certificate has been signed by the attending pr by the funeral director, page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	h 3 Ectopic pregnancy 5 Other (specify)	у		23d. Date of delik Month	ery Day Year
cords, P. wrequires that is been signed be determined by the control of the cortex of		Part II. Other significant conditions contri	buting to death but not resulting	in the underlying cause giv	ven in Part I.	_		the cause of death?
Vital Reco	e Completed	25. Was case referred to medical			26. Place of Death (C	24a. Was an autopsy performed? 1 Yes 2 N	death?	opsy findings available ompletion of cause of
Division of Vital or Attending Physicien: Tafter death. Director: After this certification by the funeral director, p	ToB	examiner? 1 Yes 2 Hos 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	pital: 1 Inpatient 2 ER/C 28a. Date of Injury (Month, Day Year) 28b.	Time of 1 28c. Injury World	ner: 4 🗆 Nursing Home			ify)
Div Ital or rs afte ai Dir	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify) ian: To the best of my knowledge			City or Town, Sta		
To the Hos within 24 hi To the Fun completely	Medical	(Check only 2 Medical Examine one) 29b. Signature and title of certifier	r: On the basis of examination a and manner stated.	nd/or investigation, in my o	opinion, death occurred a	it the time, date a	nd place, and due	to the cause(s)
4.		30. Name and address of person who com	MICC: MI pleted cause of death (Item 23a MICO) CC	(Type, Print)	le Aberd	een f	08/05 Plaza	Aberden
Stat Registra		31. Date filed (Month, Day, Year) AUG 0 9 2004	32. Registrar's Signature	Asset				

			For State Registrar	State of Ma	arylan		artment of H		nd Me		iene	004	25041
1			1. Decedent's Name (First, Middle, Las	t)					2	. Date of Deat Month	th Day	Year	3. Time of Death
	Physicia /Medic	_	Allouise E.	Cason St	over					August	4, 2	2004	12:20 PM
	Examin		4a. Fecility Name (If not institution, give				4b. City, Town, or	r Location of	f Death		4c. Co	ounty of Death	n
7			Wilson Health Car				Gaither					ntgome	
	Funeral		5. Social Security Number 6. S	9x 7. Ag □M 2 X F		last birthday)	If Under 1 Year Months Days	If Under 2 Hours	Min. 8	Date of Birth (Month, Day, ec. 3,	Year)	Col	nplece (State or Foreign untry)
	Director		224-07-9440		86	Yrs.			D	ec. 3,	1917	/ Vir	ginia
	and and		10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
	Many fett	ō	Maryland Montgom	erv		Ro	ckville						1 XYes 2 ☐ No
	288 288	Directo	10e. Street and Number		L		10f. Zip Code			1	0g. Citize	n of What Co	untry?
	death with the Maryland ms 23e or 28a-f ehow r must be notified at	0	996 Farm Haven Dr	rive			208	352		1	Unite	ed Stat	es
	death	Funerai	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Orig	gin? (Speci	fy Yes or No-	14	. Race - Ame	
	after or ite	Ē	1 Never Married 2 Married	Armed Forces?		i	1 ⊡Yes 2√2 No	Specify:	, Puerto ni	can, etc.)		Black, White	
2	hours after tural, or ite	d by	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			TEL 165 ZIG140	зреспу.			3,	pecify: W	hite ————————————————————————————————————
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N	a filed within I Hygiene. other then '		Unknown 17. Father's Name (First, Middle, Last)			Assem	bly Line			First, Middle, i			rporation
and	d is d	Be	Unknown							е М. В		amamo,	
Maryland	should ind Men marke umatic	안	19a. Informant's Name/Relationship (Type Print)		19b Mailii	ng Address (Street	and Number	or or Rural I	Poute Number	r. City or 1	own State Z	In Code)
<u>B</u>	2 6 7 8		Judith S. Morgan/				'arm Have						
ē,	os 1 and of Health item 27 r othar tr		20a. Method of Disposition	<u> </u>	20b. F		sition (Name of matory or other place		Dat	te		tion - City or	
altimore,	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif				e Cemeter		ugust 2004	/,	Staun	iton. V	'irginia
	permit. Page Department of Important: if eny injury or once.		21. Signature of Funeral Service Licer			12	2. Name and Addre	ss of Facility	y T		11	Bethe	sda-Chevy ise, Inc.
ñ	Ded on you		1 Ray Jan		M001	L98 7	obert A. 557 Wiscon	Pumphi	rey F	uneral	Home a MD	e/ Cha	se, Inc.
Е	10		23a. Part1. Enter the disease, or com shock, of heart failure. List only	plications that cause	d the deat	h. Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory arr	est,	20014	Approximate Interval Between
	Physician		Immediate Cause (Final	One cause on each	110.								Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (q) as	a conseq	uence of):	hear tery &	0					a-vecas
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Records,	uires sign	Completed by	home atre	alphul	lale	m. 6	Lyperte	we	dir	1 🗆 Y	es 2 🗆	No 3□Pr	obabły 4 🗆 Unknown
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Re	he las e has	E G	Park 1	1						autop: perfor	med?	prior to death?	completion of cause of
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Division of	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Inj	ury	28b. Time o				3d. Describe h			
ō	ath. rr: After ne funer	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		ay rour,	injury		Yes 2 🗆	No				
<u> ≤</u>	or Attencafter death Director: in by the	tific	3 Suicide 6 Could not be 4 Homicide determined		njury - At h	ome, farm, st	reet, factory, office		28	3f. Location (S City or Tow		Number or Ru	ral Route Number,
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			14. Kebell	resch	6x	mis	100	PILC	7	11 118	tug	ust	4,2004
1			30. Name and address of person who is. ROBERT BIK 31. Date filed (Month, Day, Year)	completed cause of	death (Ite)	7 23a) (Type	Print) XC/	17 H/21	RSAU	166. W	WINE	2084	7
pt.	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	trag's Sign	ature	, ,	/ - /		17			,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Of Mary (rtificate of L			g. Ng2 () () (;	25042
			Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		George I. S	isson			August	6, 2004	8:00 AM ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
ı			1921 Henry Road 5. Social Security Number 6. Sex 7. Age (In)	rs. last birthday)		Rockville If Under 24 Hrs.			gomery
	Funeral Director		578-01-9377 1™M 2□F 87	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	rthplace (State or Foreign Country) hington, D.C.
			Usual Residence of Decedent				october 2	1910 Was	
	arylan ahow	_	10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits 1 Yes 2 No
	Ba-f	Director	Maryland Montgomery			Rockville		000000000000000000000000000000000000000	1
	with ti	ā	10e. Street and Number		10f. Zip Code		10	g. Citizen of What C	
	na 23	Funerai	1921 Henry Road 11. Marital Status 12. Was Decedent Ever	n U.S. 13.	Was Decedent of Hill Yes, specify Cubar	20851 spanic Origin? (Sp	ecify Yes or No-	14. Race - An	
0	or Item		Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	i			Rican, etc.)	Black, Wh	ite, etc.
5	raf', c	d by		III	1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
ה	within 72 hours after deeth with the Maryland ene. than *natural', or Itema 23a or 28a-f ahow I a Medical Exam act must be motified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of work	ing 1	6b. Kind of Busines	s/Industry
Y	withir Bne. than	d m	Elementary/Secondary (0-12) College (1-4or 5+)	me.	Sai:			United St	ates Navy
2	be filed ital Hygi d other avant, I		17. Father's Name (First, Middle, Last)		Dai	18. Mother's Name			aces navy
land	lid be tental rked o	To Be	Herbert Sisson				Susan	Woodvill	.e
ary	is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Itam 27 is marked other then "natural", or Items 23s or 28s-f show other traumatic avant, the Medical Exam set untal he notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rur	al Route Number,	City or Town, State,	Zip Code)
Σ,	and 2 ealth m 27		Brenda S. Hoffmaster/ Daughte	r 1923	Henry Roa	ad Rockvi			
ore	Pages 1 nent of H int: If ital		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ob. Place of Dispo cemetery, cre. Gate	osition (Name of matory or other place	θ)		Oc. Location - City of	or Town, State
Saltimor	t. Pages rtment of rtant: If i		`4 ☐Donation 5 ☐ Other (Specify)	of Heave	n Cemeter	y II.	2004 S	ilver Spr	ing, Maryland
n C	permit. Pages Department of Important: If i any injury or once.		21. Signature of Foheral Service Licensee MOC	1335 R	ockville.	Maryland	L 20850 - 2	805	uneral Home/ Avenue
r			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	leath. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
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'n	tificate be executed ig physicien and as the burial-transit		resulting in death) Last . Due to (or as a cor	sequence of):					
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	ertifica ling ph e as t		IF FEMALE: 320 If was outcome of or						
X Q Q	at the death certi f by the attending stached for use a	by Physician/N	23b. Was decedent pregnant in the past 12 months?	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of d Month	elivery Day Year
o.	the de	ysic	1 Yes 2 No 9 Unknown	oru g am 5(Other (specify)				
Ţ	E 2 %	y P	Part II. Other significant conditions contributing to death but no	t resulting in the t	underlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
SD	w requires t been signe should be o						1 ☐ Ye	s 2 🔯 No 3 🗆	Probably 4 Unknown
Hecords,		Completed					24a. Was an		autopsy findings available o completion of cause of
	sician: The law certificate has t rector, page 2 s	mo:					perform	ned? death	es 2 No
Vital	ertifican:	Bec	25. Was case referred to medical examiner?				th (Check only one		
0	Physician: this certific ral director,	2	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4 Nursing H		nce 6 Other (Sp	pecify)
	ding F th. : After s funera	Certification:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident Investigation	28b. Time (Injury	Worl	yat k? Yes 2 □No	28d. Describe ho	w injury occurred	
DIVISION	Atten ir dea ector by the	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury	At home, larm, si	treet, factory, office				Rural Route Number,
ā	Hospitel or Attending 14 hours after death. Funerel Director: Atter tely filled in by the fune		4 Homicide Setermines building, etc. (S)	recity)			City or Town	, State)	
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer.	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my and manner stated.	knowledge, dea mination and/or in	ith occurred at the tim nvestigation, in my of	ne, date and place, pinion, death occui	and due to the ca red at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2 To the complet	Ž	29b. Signature and title of certifier		29c. Licensi	4 .	29	d. Date signed (Mo	nth, Day, Year)
)	\		HAMMETTMO)	D3	9966		860	04
11	1		30. Name and address of person who completed cause of death						
		210	Carolyn A. Hammett, M.D. 1835 31. Date filed (Month, Day, Year) 32. Requestrar's 33.	Univer	sity Boul	evard Hya	ttsville	, Marylan	d 20783-4657
	Sta Regist		31. Date filed (Month, Day, Year) AUG 0 9 2004 32. Registrar's 5	in B	spork				
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	Unnond	i t	State of Maryland / Department of Health and Mental Hydrogram # 23a,27,28a-f,per ME,G834,8428ilate To Death	giene Reg. No. () () ()	2501.3
	onpend	IL	1. Decedent's Name (First, Middle, Last) 2. Date of Dec	ath	3. Time of Death
	Physicia /Medic		Brandon Robert Suter AUGUST		6:50P. M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE	4c. County of Death	1
7	Funeral Director		5. Social Security Number 215-27-2536 G. Sex 1 Age (In yrs. last birthday) 18 Yrs. G. Sex 18 Yrs. G. Sex 18 Yrs. G. Sex 18 Yrs. G. Sex 18 Oate of Birthday) 18 Yrs. G. Sex 18 Oate of Birthday) 19 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 10 Oays 11 Oays 15 Oays 16 Oays 17 Oays 17 Oays 18 Oate of Birthday) 18 Oate of Birthday 18 Oate of Birt	9. Birth (ay, Year) 9. Birth (7 17, 1986	nplace (State or Foreign untry) Maryland
	aryland show	7	10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Kingsville		10d. Inside City Limits 1 ☐ Yes XX No
	the M	Director		10g. Citizen of What Co	
	with the r	iDi	11711 Mohr Road 21087	U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show amy origin: or other traumatic event, the Madical Exacting register relations and once.	Completed by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, Specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
21215-0036	ithin 72 ho he. han *natur e Modical	mpieted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. Kind of Business/I Fmaily Res	spiratory
75	lied v lygie ther t	S	12th Grade Maintenance Tech. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)		
and	d be f ental l ked of c eve	To Be	Kenneth R. Suter, Sr. Kathleen T. Min	. 1000	
Maryland	shoul and Mi	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number		Tip Code)
ž	and 2 salth a n 27 ls er tra	-	Kenneth R. Suter, Sr Father 8 Farm Brook Court Perry H.	all, Maryla	nd 21128
Baltimore,	Pages 1 Sent of He int: If iten		20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cametery, crematory or other place) Parkwood Cemetery 8/7/04	20c. Location - City or Parkville,	
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Baltimore, Maryland 2120	e, Inc.	
	Physician /Medical Examiner	_	Asphysical data caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock, or head failure. List only one caused the death. Do not enter the mode of dying, such as cardiac or respiratory as shock as cardiac or respiratory as shock as cardiac or respiratory as the distance of the data of th	rrest, Association	Approximate Interval Between Onset and Death
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.O. Box 6	death certif e attending id for use a	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \) Unknown	23d. Date of deli Month	ivery Day Year
ds, P	Se jo ed	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did t	tobacco use contribute to	
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<u> </u>	Th ate pag	Com		ormed? death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Other:	one)	
of	d is	- T	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Hest	idence 6 Other (Spec how injury occurred	cify)
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	Hospite 4 hours Funeral ely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	cause(s) and manner as	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	29d. Date signed (Monti	h, Day, Year)
,				AUGUST 3,20	04
			30. Name and address of person who completed cause of d. th (Item 23a) (Type, Print) THEODOR: U.K. G. 111 Penn Street. Baltimo	Marrian	a 21201
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 32. Registrar's Signature	are Ligit A TQU	L CIZUL

Registrar
DHMH 17 Rev 1/2001

		-	For State of Maryland / Department of Health an Certificate of Death	nd Mental	Hygien	1001	2501.1.
	Physicia	-	Decedent's Name (First, Middle, Last)	2. Date Mont	of Death	ay Year	3. Time of Death
,	/Medic Examin	al -	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I		08	c. County of Dea	
	Examin	51	UNIVERSITY OF MARYENUS HOSPITAL Bellinone City			NA	
	Funeral Director		UNK, Yrs.	Min. 8. Date	of Birth th, Day, Yea 02, 19	9. Bi	thplace (State or Foreign guntry)
	faryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location WA PALTMONE				10d. Inside City Limits 1 ☐ 16s 2 ☐ No
	with the had or 28a-	Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What C	ountry?
	iter death I tems 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 2 No	n? (Specify Yes Puerto Rican, et	or No-	14. Race - Am Black, Whi	erican Indian, ite, etc.
-0036	2 hours af atural; or	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b.	Specify By	ACK s/Industry
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interpretant: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction or investice notified at 200ce.	Completed	(Specify only highest grade completed) Elementary/Second≰ry (0·12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired) AWKER	of working		enstre	iction
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Baltimore,	Pages 1 ment of He ant; If iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Date 3-7-04	20c.	Location - City o	Town, State
Balt	permit. Departr Importa any Inji		21. Signature of Experience Licence 22. Name in gradules of FAM)	ARCH HU	WIRA S BA	GONE TO	21229
	Physician		23a. Part : Exter the disease or complications that caused the death. Do not enter the mode of dying, such as ca shock or part failure. List only one cause on each line. Immediate Cause (Final disease or condition	ardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				2014
	cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
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Vita	Physiclan: this certificatal director, I	Be	examiner?	of Death (Check			
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	tion; To	27. Manner of Death 1 Nors 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work?	28d. Des		6 □Other (Sp jury occurred	ecify)
Division	I or Attending after death. I Director: After I in by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 6 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca	ation (Street or Town, Sta		Rural Route Number,
	te Hospital of 24 hours at the Funeral Distriction (illed i	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due occurred at the	to the cause time, date a	(s) and manner a nd place, and du	as stated. te to the cause(s)
	To the h within 24 To the f complete	Me	29b. Signature and title of certifier 29c. License number		1	ate signed (Mor	oth, Day, Year)
			P1656	01		8/2/04	/
	\	N/	30. Name to a Theorem on who completed cause of death (Item 23a) (Type, Print) 22 South GREENE St. B. Himure MD 21201 Mg.	IID CIN	A, MD		
	Sta Registi	_	31. Date filed (Month, Day, Year) AUG 0 9 2004 32. Registrar's Signature	,			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month Geoffrey A. Tizard 2004 Aug. 8:20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Greater Baltimore Medical Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F Days Hours Director 26, 1929 Washington D.C 579-34-1765 Jan. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ma 23a or 28a-f show 1 Yes 2 No Funeral Director Md. Baltimore Towson 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? death with 21204 USA 8200 Carrbridge Circle 12. Was Decedent Ever in U.S. Armed Forces? or itema Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. fited within 72 hours after 1 Types 2 No
If Yes, Give
Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Officer AT&T othar permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: if Item 27 is marked othi any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be George F. Tizard Catherine Maury 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Towson, Maryland 21204 Mrs. Grace A. Tizard/Wife 8200 Carrbridge Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Creenation 3 ☐ Removal from State 4 □ Donation 5 Qother (Specify) Entemb Dulaney Valley Mem. Grd. 8/9/04 Timonium, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fundry 1050 York Road Towson, Maryland 21204 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neumonca **Physician** 5 days /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician a ned for use as the burial-P.O. Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) TYPS 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No After this certificate has 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Pinpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 - Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) touverne 02473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Touson MD2/204 Jouweine Mo 32. Registrar's Signature State Registrar

		•	For State Registrar	State of Ma	•	partment of I			jiene	Management of the second	25046
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	Day	Yeer	3. Time of Death
	Physicia /Medic		LeRoy	Robert	Taylor			August	6, 2004		5:45 PM
	Examin	_	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County		
			8029 Dalesford 5. Social Security Number 6. Securi		(In yrs. last birthda		(Ville If Under 24 Hrs.	9 Date of Birth		imor 9 Bidbo	
	Funeral Director			DM 00 C	7 (<i>III yrs. iasi birilida</i> 13 Yrs.	Months Days		8. Date of Birth (Month, Day	7.1910	Cour	lece (State or Foreign http) Jersey
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	how		10a. State 10b. County		10c. City, Town or					1	Od. Inside City Limits
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	or 28	Die	10e. Street and Number	D (10f. Zip Code	21.	1	log. Citizen of W	/hat Cour	ntry?
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Iteme 23s or 28s-f show that the Medical Examinar must be neitified at	Completed by Funeral Director	8029 Dalesford	12. Was Decedent E	Type in 11 C 1	21 23		pacify Vas or No-	USA 14 Bace	a - Americ	an Indian,
	ltem Item	nue	11. Marital Slatus 1 ☐ Never Married 2 ☐ Married	Armed Forces?	lo	Was Decedent of If Yes, specify Cub	oan, Mexican, Puert	o Rican, etc.)	Blac	k, White,	
36	irs aff	by	3 ☐ Widowed 4 ☐ Divorced	1 XX Yes 2 ☐ N If Yes, Give Year or Dates: ☐	Multi	1 ☐ Yes 2 🂢 No	Specify:		Specify	Шh	ite
21215-0036	2 hou	ted	15. Decedent's Ed	ucation	16a. De	cedent's Usual Occu	pation	tkina	16b. Kind of Bu	siness/In	dustry
215	thin 7	ple	(Specify only highest gra	College (1-4or 5	+)	ve kind of work done a. DO NOT use retire	ed)	All Ig	6		
	filed withi Hygiene. other than	00	12		El	ectrician	T				lustry
pu	be fill d oth	Be	17. Father's Name (First, Middle, Last)	T1			Rosie	ne (First, Middle,	Seiffer		
3	nould be d Mental narked o	P	Robert A. 19a. Informant's Name/Relationship	Taylor	10h M	ailing Address (Stree					
Maryland	d 2 sho		Ruth B. Loughman		1	29 Dalesfo			ille Mar		
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused one cause on each lin	the death. Do not						Approximate Interval Between
	Physician	2 7	Immediate Cause (Final disease or condition	Gene		+A 69	neword	leveris			Onset and Death
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687	that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit	_		. G							
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_	death	lcla	in the past 12 months?	4☐Pregnant at		5 Other (specify)			Mor	nth	Day Year
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Vital Records,	Physician: The this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0	than	ath (Check only o		5.0	
of	Phys r this ral di		1 Yes 2 No 27. Nanner of Death	28a. Date of Inju		e of 28c. Inju	ury at		lence 6 Other		(y)
on	ding F th. : After funera	tlor	1 Natural 5 Pending 2 Accident investigatio	(Month, Da	y Year) Inju	y W	ork? ☐ Yes 2 ☐ No				
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Ö	el or s afte el Dire	Certification:	4 Homicide	building, et	c. (Specify)			City of Tow	m, State)		
	To the Hospitel or Attending Ph within 24 hours after death, To the Funerel Director: After th completely filled in by the funeral	cal	29a. Certifier Certifying Pt	ysician: To the best niner: On the basis o	of my knowledge, d	eath occurred at the	time, date and place	a, and due to the	cause(s) and ma	inner as s	stated.
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	To T	Σ	29b. Signature and title of certifier	Time V	D.		nse number	3	29d. Date signed	1 (Month,	Day, Year)
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	10		30. Name and address of person who	completed cause of c	leath (Item 23a) (Ty	pe, Print)	750	5 Osler	Drive	Tai	oy wion Mb
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #1 PER PHY G834 8/ODE/OAicalle of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ALICE BERG Alice Berg Tobler MD TOBLER 6,2004 August 4:04 a. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Broadmead Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 219-36-1859 99 Nov. 14, 1904 Director Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d, Inside City Limits item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Madical Examinal Trust be netitied at 1 ☐ Yes 2 ☐ No Director Baltimore Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13801 York Road 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2□ No If Yes, Give Year or Dates: Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Man injury or other traumatic event, the Man Medical Doctor State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adolph Berg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Mary Overstreet(Friend) 13801 York Road Cockeysville, Maryland 21030 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State Greenmount Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 8/7/04 Baltimore, Maryland 2 Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each jine. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) the attending physician 68760 Physiclan/Medical as the IF FEMALE Box use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the death ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2€No Ö 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death 23e. Did tobacco use contribute to the cause of death? not resulting in the underlying cause given in Part I. Records, pe 2 No 3 Probably 4 Unknown leted page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificete 2 No Vital 1 Yes 25. Was case referred to medical examiner? in by the funeral director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 2 No 2 ER/Outpatient 3 DOA ō this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 5 Pending investigation Natural Injury death. 1 TYes 2 No 2 Accident after death Director: 3 🖺 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 filled Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 22627 30. Name and address of per gause of death (Item 23a) (Type, Print) 13801 YORK Rd, COCKEYSVILLE, MD 21030

State

AUG 0 6 2004

31. Date filed (Month, Day, Year)

BROADHEAD, 32. Registrar's Signature

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death August 04 2004 Yeer 7:45 a M **Physician** Kathryn Buckley Wetzel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Towson Baltimore **Blakehurst** If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, AUG. 01 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 🕱 F 88 324-30-1407 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Towson Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 W. Joppa Rd. 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traument. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ **X**10 Baltimore, Maryland 21215-0036 Specify Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Ann Melchoir Joseph Langdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 West Willow Grove Ave. Philadelphia, Pa. 19118 Mr. James Buckley/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Hill Cemetery 8-5-04 Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Segvice Licensee softer Tuperal Hope 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mo **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 90 nowsel 2 No 3 Probably 4 □Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 27. Manne of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Aug 04, 2004

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAY

30. Name and address of person who completed ca

32. Registrar's Signature

6

Energy & Signature

of death (Item 23a) (Type, Print)

		1	For State Registrar	State of Ma	aryland		irtment of F				ene 2004	25049
			Decedent's Name (First, Middle, Last	st)						2. Date of Death		3. Time of Death
	Physicia /Medic		William	Paul Wo	odri	ng				August	3 2004 Year	8:00am
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o				4c. County of Deat	
			3 Gladiolus F				Midd If Under 1 Year		r 24 Hrc	O Data of Blah	Baltimor	and and Action of English
	Funeral Director		5. Social Security Number 6. S 214-26-9335	ex OXXM 2□F	e (In yrs. las 74	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day,	1929West	oplace (State or Foreign Virginia
	ס		Usual Residence of Decedent		T.:							
	show	.	10a. State 10b. County MD Balti	moro	10c. City, 7		cation ddle Ri	ver				10d. Inside City Limits 1 ☐ Yes 2 💆 No
	28e-f	Director	MD Balti	.more		1,177	10f. Zip Code	VC1		10	g. Citizen of What Co	untry?
	with I		3 Gladiolus Pl	300			2122	0			JSA	
	ms 23	Funeral	11. Marital Status	12. Was Decedent		13.	Was Decedent of H		rigin? (Spe	cify Yes or No-	14. Race - Ame Black, White	
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland to fleatin and Mental Hygiene. If item 27 is marked other then "naturel", or items 23a or 28e-f show If item 27 is marked other then "naturel", or items 23a or 28e-f show or other traumatic event, the Marical Examinat her rivilliad and	Fur	1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ If Yes, Give		1	ilos, specily cub 1 □ Yes 2 □ No			nouri, etc.,	Specify:Wh	
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Mar	12 sh th and 7 Is m traum		19a. Informant's Name/Relationship (1						ore MD 2	
	1 and 2 Health tem 27 other tra		Lena Woodring 20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of				20c. Location - City or	
<u>o</u> E	Pages nent of I ant: If its ary or o		Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Special	Removal from State b)	Hol	lÿHi	natory or other pla 11Cemet	ery	8/6	/04	Baltimore	e MD
Baltimore,	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Lice	nsee /	10.	22	Name and Address 300 Ma		-		FuneralHoore MD 2	omeofEssex
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Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			0:	han		(Check only on		-76.3
of	T - @	: To	1 Yes 2 No 27. Manner of Death	28a. Date of Inj (Month, Da		R/Outpatie 8b. Time c	nt 3 DOA	4 🗀 1		-/-	nce 6 Other (Spe w injury occurred	cny)
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	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical	29a. Certifier 1 ← Certifying P (Check only 2 ← Medical Example)	miner: On the basis of and manner s	of examination	on and/or in	vestigation, in my	opinion, d	eath occurre	ed at the time, da	ate and place, and due	to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month Physician Joseph B. Wible August 2004 1630 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolitan Assisted Living Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) March 13 1909 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 MM 2 □ F 95 176-07-9968 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County or Items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at Md Anne Arundel 1 Yes 2 No Annapolis Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 411 Walnut Avenue 21403 USA Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No WWTT If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-tif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white Specify: Be Completed by 3 ♥ Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "any injury or other traumatic event, ILEME any injury or other traumatic event, ILEME DIGE. College (1-4or 5+) Elementary/Secondary (0-12) Social Security Adm. Section Chief ۷, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Wible Jean Cope ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) J. Scott Wible (son) 411 Walnut Avenue, Anna olis, Md 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 8-9-04 Sykesville, Md 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee, P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) OPD Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate ba exacuted burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signad by the a d ba detached f ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1 ☐ Yes certificete 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 ☐ Yes 2 ☐ No this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of tnjury (Month, Day Year) 28b. Time of 27. Manner of Death Medical Certification; 5 Pending investigation 1 Natural efter death.
I Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours e To the Funeral I Varieting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 08-09.2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Agricago lis, 2003 State Registrar

Unperio I tem#23a,24a,27,28a I perme,8/20/04 II Copies Are Legible.

		For State Registrar	Otato of In	iai yiane	-	rtment of l				g. No. ()	1	250	151
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Funeral Director		5. Social Security Number 6.5 212 78 7670	V	ge (In yrs. la 45	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	B. Date of Birth (Month, Day, June 27	^Y ° 1 ′959	9. Birthp Coun	lace (State try) Md	or Forei
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or itams	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 V If Yes, Give Year or Dates	? No	,	Was Decedent of f Yes, specify Cul	oan, Mexican	ı, Puerto Ri	ify Yes or No- ican, etc.)	Bla	ce-Americ ck, White, y: Whi	etc.	
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and Mental Hyglene. is marked othar than aumatic event, the M	To Be	17. Father's Name (First, Middle, Last John M. Wimse					18. Mothe		First, Middle, M oris Bi		ne)		
27 is ma r traums		19a. Informant's Name/Relationship Juanita Sipes (Si	**		1	ng Address <i>(Stree</i> Baltimon				-		Code)	
Item 27 i		20a. Method of Disposition	75 14 00		lace of Dispo	sition (Name of natory or other pl	ace)	Da	te 2	Oc. Location	- City or To	wn, State	
unt: if		1 ☐ Buriał 2 🏋 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci				y Cremat		8/4/2	004	Sykesv	ille,	MD	
Department of the important: if its any injury or or once.		21. Signature of Funeral Service Lice	Haigh			Name and Add laight Fi Box 195					Litt ttles	le's town,	F.H PA
physician and maintenant the burial-transit	Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate auss (Disease or injury that initiated events resulting in death) Last		ic (Me	ethado uence of): uence of):	ne) Into						Interval B Onset an	
r this certilicate has been signed by the attending physicis	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	Ideath 3[eath 5[□Ectopic pregnan □ Other (specify)				М	ate of delive	Day	Year
signed I be d	by	Part II. Other significant conditions	contributing to death	but not rest	uiting in the u	nderlying cause g	iven in Part i	1.		acco use con	3 Prob		
has been si ge 2 should l	Completed								24a. Was ar autops perforn	y ned?	Were auto prior to co death?	mpletion of	gs availa f cause
certificate ha	ပိ	25. Was case referred to medical					OS Plans	o of Dooth	(Check only on		1 🗆 Yes	2□ No	
nis certifica director, p	o B	examiner?	Hospital: 1 ☐ Inpa	tient 2 🗆	EB/Outpatie	nt 3 DOA	thor		e 5 ☐ Reside		her (Specif	v) At	Scen
After this funeral o	-	27. Manner of Death	28a. Date of In	iury	28b. Time o	f 28c. Inj			Bd. Describe ho			,, 220	
leath. tor: After the funer	atio	1 □Natural 5 □ Pending 2 □ Accident investigate	n Found	/2/04	Food 10		Yes 2X	No	U	nknown			
after death. I Diractor: After	Certification:	3 ☐ Suicide 6 🛎 Could not 4 ☐ Homicide determined	building,	njury - At ho etc. <i>(Specif</i>) arkin		reet, factory, office	Э	2		wood (Circl	e	umber,
within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical C		hysician: To the bes miner: On the basis and manner	st of my kno of examina	wiedge, deat				nd due to the ca		anner as s	tated.	e(s)
within To the	Me	29b. Signature and title of certifier	16-8-	mj)	29c. Lice	nse number		2:	ed. Date signe August)
		30. Name and address of person who	completed eause of			Print) n Street	- เกา	-im	Mərx-	land 21	201		

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		1 - State Registrar		Cei	rtificate of l	Death		Reg. No.	25052
Dhysic	ion	Decedent's Name (First, Middle, La					2. Date of De	Day Year	3. Time of Death
Physic /Med		Paul	Joe	Watkins			July	28, 2004	0256 M
Exami		4a. Facility Name (If not institution, giv	e street and number)	4b. City, Town, or	Location of Dea	th	4c. County of Deeth	
		Peninsula Reg	ional Me	dical Ctr	Sal:	isbury		Wicom	ico
Funera		5. Social Security Number 6. S		ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs		th 9. Birth	place (State or Foreign
Director		238-66-6061	□ M 2□ F	61 Yrs.	Months Days	Hours Min	Nov 9	, 1942 N.C	arolina
7		Usual Residence of Decedent						, ->	<u> </u>
ylan		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
Ma Ma	Į.	MD Wicom:	ico	Sal	isbury				1x□xYes 2 □ No
r 284	e e	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
3a o	9	522 Winners S	treet	Apt. 49		21801		USA	
death with the Maryland ms 23a or 28a-f show final by rodified at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Specify Yes or No)- 14. Race - Ameri	
fter of transfer of the restriction of the restrict	Ē	1 🛣 Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 🛣	No		ın, Mexican, Pue	rto Rican, etc.)	Black, White	, etc.
or in	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 24 ☐ No	Specify:		Specify: B1	ack
3-UUSO 72 hours after natural', or ite	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Business/Ir	ndustry
nin 7	pe	(Specify only highest gra		(Give	kind of work done of DO NOT use retired	during most of wo d)	orking		
d Z I Z I	E	Elementary/Secondary (0-12) 11th	College (1-4or	5+)	Labore	o r		Lumber Co	mnanv
nd ZIZI e filed within al Hygiene. I other then "		17. Father's Name (First, Middle, Last,)				me (First, Middle,	, Maiden Sumame)	puilj
Id be file fental Hy ked oth	o Be	Joe Watkins				Caro1	ine Da	avis	
In a mark	10	19a. Informant's Name/Relationship (Type Print) ()	. 1 19h Mailie	n Address (Street	and Number or B	Pural Route Numb	er, City or Town, State, Zi,	in Code)
Mar od 2 sho lith and 27 15 my		Caroline D. Wa	(110					n, NC. 280	
than		20a. Method of Disposition	CKIIIS				Date	20c. Location - City or T	
Pages nent of the int. If its		1 Disposition 3 □	Removal from State	20b. Place of Dispo cemetery, crei					
Pa men men ant:		'4 ☐ Donation 5 ☐ Other (Specif		Stanley	Mem Gro		04/04	Albemarle	
DAILIMOT permit. Pages Department of t important: if tte any injury or or once.		21. Signature of Funeral Service Licer	nsee	22	2. Name and Addres	ss of Facility Ro	nald A	. Grayson	F.H.P.A.
		() Lenald ()	Granse	1	08 W. No	orth Av	re. Balt	to, MĎ. 21	202
		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
Physician	6.0	Immediate Cause (Final			enelina	1.000	1. 00	cident	Onset and Death
/Medical		disease or condition resulting in death)	a. Due to /or as	a consequence of):	CBrow	asce	a me	CICI + AT	
Examiner			//	a consequence of.	1				
	ē l	Sequentially list conditions, if any, leeding to immediate	b. Due to (or as	nsequence of):	210~				
ted sit	듣	cause. Enter Underlying Cause (Disease or injury	11.	1.2-1.2	lan :				
xecu and	Examiner	that initiated events resulting in death) Last	C. Due to (or a	consequence of):	remia				
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= 2,10	₩e	IF FEMALE:	23c. If yes, outcome	of prognancy				Tiffi	
ath cer ttendir	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	rery Day Year
e de the a	20	1 Yes 2 No	4∐Pregnant a 9☐Unknown	t time of death 5	Other (specify)				
at the day a betach	Physician/M					300.000	1		
s the gned	by	Part II. Other significant conditions of	4	out not resulting in the u	nderlying cause give	en in Part I.		obacco use contribute to	
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he la he has	Ē							prior to content death?	ompletion of cause of
on of vital necoding Physician: The taw h. After this certificate has tuneral director, page 2 s	ပိ	25. Was case referred to medical					1 □ Yes	2 No 1 Yes	2 □ No
VI Bicia Certi	m	examiner?	Hospital:		t 313 DOA Othe	00	ath (Check only o		
Phys rathis	1°	1 Yes 2 No 27. Manner of Death	28a. Date of Inj	ent 2 ER/Outpatier	IL SELDON	4 Nursing		dence 6 Other (Speci how injury occurred	fy)
JING	0	1 Natural 5 ☐ Pending	(Month, D	ay Year) Injury	Worl		28d. Describe	now injury occurred	
ttending death. tor: Afte the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No			
or At ter of irect	Certification;	4 Homicide determined	280. FIZCO OF IT	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		28f. Location (.	Street and Number or Rur wn, State)	al Route Number,
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	S								
hou nel	ca	29a. Certifier 1 ☐ Certifying Pr	nysician: To the besi	of my knowledge, death	occurred at the tim	ne, date and plac	e, and due to the	cause(s) and manner as a date and place, and due to	stated.
he H in 24 he F piete	edical	one)	and manner s	tated.	vestigation, in my of	piritori, death occ	ar the time,	date and place, and due i	to the cause(s)
To t To t	Σ	29b. Signature and title of certifier	7/	M . %	29c. License	e number		29d. Date signed (Month,	Day, Year)
		Turne 10	13aa	in Mis	D14	1256		7/29/	24
/		30. Napre and address of person who	completed cause of	death (Item 23a) (Type.	Print) Print	LAKE -	GREET	11-116	
5		Hanea W	ISAACS	death (Item 23a) (Type,	SALICI	BURGE M	Un 2/90	/-	
S	tate	31. Date filed (Month, Day, Year)		rar's Signature	-11431	4004	4 -100		
Regis		ntin h	Ø >	1 4					
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()	-501			ORIGIN	AL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Verna G_{\bullet} Wolff August 5, 2004 7:30am /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 507 East Clement Street Baltimore City Months Days Hours Min. 8. Date of Birth (Month, Day, Year) September 5, 1924 5. Social Security Number 213–20–9829 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)

VA **Funeral** 79 1 ☐ M 2 🔀 F Yrs. Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location or then "natural", or Itams 23a or 28a-f show The Medical Examiner must be notified at 10d. Inside City Limits MD N⁄Α Baltimore City XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 E. Clement Street 21230 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a any injury or other treumatic event. If a Medical Everticet must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) during most of working College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willard Williams Enola George 19a. Informant's Name/Relationship (Type, Print)
Debra A. Wolff / Daughter In-Law 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Fast Clement Street, Baltimore Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State **®**Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery Aug. 9, 2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hear disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a Offer significent conditions contributing to death but not resulting in the underlying cause given in Part I. Part II 23e. Did tobacco use contribute to the cause of death? þ ate has been signification 12 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. 28d. Describe how injury occurred After 1 Injury at Work? Natural Injury within 24 hours after death. To the Funarel Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print), 30. Name and address of person wi m L85/10 (MZ 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 0 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2004 Elizabeth Louise Williamson August 6, 7:10A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5100 Dorset Avenue, Apt. 107 Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 18, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 💢 F 95 Yrs West Virginia 1909 Director 577-46-9125 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Show 10a. State 10b. County or items 23e or 28e-f shov directivest be notified at 1X Yes 2 No Director Maryland Chevy Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5100 Dorset Avenue, Apt. 107 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed by 3 XWidowed 4 ☐ Divorced White "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Nursing permit. Pages 1 and 2 should be file.
Department of health and Mental Hygi
Importent: If Item 27 le marked --any injury or other th--once. treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Newkirk Cunningham Jane Elizabeth Stehley 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth W. Bruner/Daughter 6665 Fairfax Road, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory August 7, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue

• M00803 Bethesda, Maryland 20814-3501 21. Signatu of Ineral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 2 Weeks /Medical Due to (or as a consequence of) Examiner Years Coronary Artery Disease Sequentially list for cities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 🗓 No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Pneumonia 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death? Senile Dementia certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2X No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2X No this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: / d in by the f 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide n 24 hour. Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Sign tur ar 29c. License number 29d. Date signed (Month, Day, Year) D09764 August 6, 2004 address of person who completed cause of death (Item 23a) (Type, Print) 6000 Executive Boulevard, Suite 300, Rockville, Maryland 20852 Joel Reiskin, M.D. 31. Date liled (MorAUG, 0°9 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** August 4, 2004 John R. Waller 2:20A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**∑**M 2□F 73 577-42-4377 July 17, 1931 Washington, DC Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or Items 23a or 28a-f show traumatic event, Ite Medical Examit or most to collised 1 Yes 2 No Directo Maryland | Montgomery Kensington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20895 United States 5011 Orleans Court 22. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours atter 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☐X No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Tax Consulting Lawyer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fit thent of Health and Mental H tant: If itam 27 is marked other. Austin Cooper Waller Fannie May Trimble 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rita L. Waller/Wife 5011 Orleans Court, Kensington, Maryland 20895 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition August 10, 1 X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ö * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signatura, L.Furreral Service Licensee Bethesda-Chevy Chase, Inc. Bethesda, Maryland 20814-7557 Wisconsin Avenue M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** 8 Months Transitional Carcinoma of the Bladder /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Recurrent Sepsis with Pseudomonas, Other 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2∑ No Gram-Negative Organism, Staphylococci and Yeast Yes 2 □ No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27 Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours atter death. To the Funeral Director: Atter th completely tilled in by the funera Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) Michael a. Westerman, M.D. D52451 August 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. Box 2316, Kensington, Maryland Michael A. Westerman, M.D.

State Registrar 31. Date fited (Month, Day, Year)

AUG 0 9 2004

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OF

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32. Registrat's Signature

		·	1 - For State Registrar	State of Maryland		rtment tificate				R	eg. No. ()	04	25056
	Physici /Medio		1. Decedent's Name (First, Middle, Last Clara Jean	W11502					A	Date of Deat Month	Day	Year 2004	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give Union Memorial 5. Social Security Number 6. Se	Huspital x 7. Age (In yrs. 1	ast birthday)	BA A	Hymer 1 Year	If Under 2	4 Hrs. 8	Date of Birth	1	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	DM 3€F 58	Yrs.		Days	Hours	Min.	anuary.		6 M	2.70
	the Marylan 28e-f show potilled at	ector	10a. State 10b. County M.D Wa		Atmos		Codo				On Citizen		0d. Inside City Limits 1 ☑ es 2 ☐ No
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any night of other treumatic event, the Madical Examinatorium is notified at once.	by Funeral Director	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	STreet Apr. 12. Was Decedent Ever in U. Amed Forces? 1 Yes, Give Year or Dates:	S. 13. W	21	ent of His	panic Orig , Mexican,	in? (Specir Puerto Ric	y Yes or No- can, etc.)	<i>U.</i>	of What Cour 5. A. Blace - Americ Black, White, cify: Blace	an Indian,
	within 72 ho iene. then "netur the Madical I	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation te completed) College (1-4or 5+)		ent's Usual kind of work O NOT use	k done di e retired)	tion uring most	of working		. /	Business/In	dustry
Maryland 2	should be filed within 72 hours nd Mental Hygiene. marked other then "neturel", imatic event, the Madical Exa	To Be Co	17. Father's Name (First, Middle, Last) Fessie Wilson 19a. Informant's Name/Relationship (T					Low	:16	First, Middle, I	E		Code
Baltimore, Ma	it. Pages 1 and 2 shortment of Health and creent: if item 27 is minjury or other treum:		20a. Method of Disposition 12 Serial 2 Cremation 3 1 4 Donation 5 Other (Specify,	20b. P	Jace of Disposemetery, crem	& On sition (Nam- latory or oth	VEN e of her place	5+	Bulg	tmon;	MD c	DI 21 3	own, State
Balt	permit. Depertin Importe any inju		21. Signature of Funeral Service Licens		22.	Name and	d A dress	s of Facility	BEHS	Funers	1. HET	me MD Z	
	certificate be executed ding physician and see as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate tause. Little underlying Cause (Disease or injury that initiated events resulting in death) Last	a. SEPSIS Due to (or as a consequence of the consequence) Due to (or as a consequence) CAVITAR Due to (or as a consequence)	uence of): C Ru uence of):		L	70156			est,		Approximate Interval Between Onset and Death O days
. Bo	death e atter	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	o. 23c. If yes, outcome of pregna 1	death 3	Ectopic pre Other (s <i>pe</i>						Date of delive Month	Dry Day Year
	requires that the de sen signed by the a rould be detached f	by	Part II. Other significant conditions co	entributing to death but not resu	ulting in the un	derlying ca	tuse give	n in Part I.					ne cause of death?
Rec	The law ite has by	Completed						<u> </u>	_ "	24a. Was a autops perforr	ned?	b. Were auto prior to condeath?	psy findings available mpletion of cause of
on of Vital	ding Physician: Th n. After this certificate funeral director, pag	To Be	27. Manner of Death 1 SNatural 5 Pending	Hospital: 1 Minpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Othe Bc. Injury Work	r: 4 🗆 Nur	sing Home	Check only on 5 ☐ Reside d. Describe ho	ence 6 🗆 (v)
É	To the Hospital or Attending Ph within 24 hours atter death. To the Funerel Director: After thi completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			33 42.		Location (St City or Town		mber or Rura	l Route Number,
	he Hospital in 24 hours a he Funerel pletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	vsician: To the best of my kno- iner: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deatl	place, and	d due to the ca at the time, d	ause(s) and ate and plac	manner as st	ated. the cause(s)
<i>v</i>	To the within 2 To the Complet	Σ	30. Name and address of person who continued the control of the co	ompleted cause of death (Item	1 23a) (Type, F	F		243		46 1	AUGU		, 2004
't	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 9 2000	32. Registrar's Signa		UA	JIVE	RSIT	Y PA	IRKWA	4 ,	BALTI	MORE MI

		For State Registrar	State of Ma	-	-	of Health and of Death	Reg. N	001	2505
Physicia	an	Decedent's Name (First, Middle, Land)	Mildred	Eva	Zajdel		2. Date of Death Month D July31	ay Year	3. Time of Dea 7:20r
Medic/ Examin		4a. Facility Name (If not institution, gi	ve street and number)	1	4b. City, 1	Town, or Location of Dea		c. County of Deat	h
		Stella Maris				owson		altimor	
uneral irector		217-18-9207	Sex 7. Age 1 □ M 2 🙀 F	(In yrs. last birthe	Months	1 Year If Under 24 Hrs Days Hours Min		r) Co	hplace (State or Fo. untry) aryland
now at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Li
a-f sh	cto	MD Balt	imore	W	hite M	larsh			1 ☐ Yes 2 ∑
or 28	Dire	10e. Street and Number	C	Dood	10f. Zip		_	itizen of What Co	untry?
s 23a	rall	11230 Bird R:	12. Was Decedent E		13 Was Doord	21162		SA 14. Race - Ame	erican Indian
item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 YN If Yes, Give Year or Dates:		If Yes, spec	ent of Hispanic Origin? (. ify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White	e, etc.
atural ical Ex	ted b	15. Decedent's 1	ducation	16a. C	ecedent's Usua	l Occupation	16b.	Kind of Business	
Wad	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5-		omemak	k done during most of we e retired)		wn home	
other than vent, the Me		8th	6)	11	Omeman		ame (First, Middle, Maide		
arked ot	Be	17. Father's Name (First, Middle, Las Joseph Roth	t)				Antkowski	ar Jumamo,	
Is marked a	2	19a. Informant's Name/Relationship	(Type, Print)	19b. I	Mailing Address		Rural Route Number, City	or Town, State, 2	Zip Code)
27 Is ar trau		Edwin J. Zajde	el Sr/ s	son 1	04 She	ll Cove C	ourt Joppa		
		20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. Place of D	Disposition (Nan crematory or of	ther place)		Location - City or	Town, State
ant: If It ury or o		'4 □ Donation 5 □ Other (Spec		Loudo	n Park	8/	6/04 Ba	altimor	е
Important: If I any Injury or once.		21. Signature of Funeral Service Lic	ensee	11	22. Name an	d Address of Facility	ConnellyFu	neralHo	omeofEs
rsician ledical aminer	er	23a. Part 1. Enter the disease or co- shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. ACUTE M. Due to (or as a		CYTIC L				Interval Betwee Onset and Dea
and transit	amlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
sician and burial-tra	Exa	resulting in death) Last	Due to (or as a	a consequence of):				
hysici he bu	lcal	•	d			; <u> </u>			
ed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp			23d. Date of de Month	livery Day Yea
De pe	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying c	ause given in Part I.	23e. Did tobacc	_	o the cause of deal
been si should	letec						24a. Was an	24b. Were a	utopsy findings ava
this certificate has al director, page 2	Completed						autopsy performed? 1 Yes 2 X	prior to death?	completion of caus
certifi	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only one) Home 5 Residence	6 MOther (Cas	HOGDT
After this funeral di	To To	1 ☐ Yes ②X No 27. Manner of Death	28a. Date of Injur (Month, Day		me of 2	8c. Injury at Work?	28d. Describe how in		cify) HOSPI
offe ane	Certification:	1 XNatural 5 Pending 2 Accident investigat 3 Suicide 6 Could not determine	be 28e. Place of Inju	ury - At home, fari	М	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	and Number or R	ural Route Number
octor: A		4 Homicide	building, etc	э. (эрөспу)			July of Town, St	210/	
neral Director: A filled in by the fu	al Certi	29a. Certifier 1 X Certifying	Physicien: To the best of	of my knowledge.	death occurred	at the time, date and pla	ce, and due to the cause	(s) and manner a	s stated.
To the Funeral Director: A completely filled in by the fu	edical Certi	29a. Certifier 1 X Certifying	Physicien: To the best of eminer: On the basis of and manner sta	examination and	death occurred /or investigation	at the time, date and pla , in my opinion, death oc	ce, and due to the cause curred at the time, date a	(s) and manner a and place, and du	s stated. e to the cause(s)

Registrar
DHMH 17 Rev 1/2001

State

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 0 \$ 2004

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.
32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month July 25, **Physician** 2004 3:00 p\m Helen H. Alexander /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Williamsport Homewood at Williamsport If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 WV **Funeral** 1 ☐ M 2 🔀 F 92 212-38-7201 12/04/11 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show Examiner must be notified at 1 ☐ Yes XXNo Gerrardstown WV Berkeley Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 25428 U.S.A. 78 Hawks Nest Trail items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed by 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4or 5+) Practical Nurse Health 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ida Florence Hyre Vernon Preston Hedrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nit. Pages 1 and 2 ertment of Health a crtant: If Item 27 is 78 Hawks Next Trail, Gerrardstown, WV25428 Delores A. Bowen/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/04 Westernport, MD Philos Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) permit.
Deportrainments
any nju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Markwood Fureral Home, .Q. Box 012, Keyser, WV UN P 23a. ant. Enter the disease, or complications that caus shock, or heart failure. List only one is use on each the death. Do not enter the node of dying, such as cardiac or respiratory arrest, tmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispace or a part) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): O. Box 68769 Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 □ Unknow6 δ ے 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 LANo certificate 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 3 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To this 27. Magner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funerel Direct 4 Homicide 29a. Certifier 🎜 ortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) completely and manner stated. the 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature 1107 ause of death (Item 23a) t77tov € 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2004 Registrar

DHMH 17 Rev 1/2001

Helen Alexander

78		1	For State Registrar	State of Marylan		artment of H			giene Reg. NG.	25050
}	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Las DouglaS 4a. Facility Name of not institution, give	street and number)	1	Baubli 4b. City, Town, or	Location of Dea	2. Date of Dea Month	Day Year 2 004 4c. County of Deat	
	Funeral Director		Social Security Number 6. S	TAGE (In yrs.)		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) Co	thplace (State or Foreign buntry) PA
	s within 72 hours after death with the Maryland jiene. r than "natural", or items 23e or 28e-1 show the Majical Evan it at must be notified at	Funeral Director	10a. State 10b. County	York We	y, Town or Lo est Ma	nchester 10f. Zip Code	Twp., Yo	ork	10g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☐ No puntry?
9036	ours after death iral', or items 23 Evanti et mus	۵	11. Marital Status 1 □ Never Married 2	12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【X No	ispanic Origin? (n, Mexican, Puel Specify:	Specify Yes or No rto Rican, etc.)	14. Race - Ame Black, Whit Specify:	White
d 21215-0036	y within piene. r than the Me	e Completed	15. Decedent's Edition (Specify only highest grade) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5+) 4	(Give	dent's Usual Occup kind of work done DO NOT use retired hool Teac	during most of wo her		Public Scl Maiden Sumame)	•
Maryland	s 1 and 2 should be filed f Health and Mental Hyg Item 27 Is marked othe other treumatic event,	To Be	Russell Wilson 19a. Informant's Name/Relationship (Nadra A. Baublitz	Type, Print)		ng Address <i>(Stre</i> et Trinity	and Number or F	Beatrice Bural Route Number ck, PA	Kendig er, City or Town, State, . 17404	Zip Code)
Baltimore,	permit. Pages 1 ar Department of Hea Importent: If Item 3 eny Injury or other once.		20a. Method of Disposition 1 □ Burial 2 ☒ Cramation 3 ☒ 4 □ Donation 5 □ Other (Specification of Specification of Specifica	Removal from State YO	Place of Disponentery, cre cktown Servi	osition (Name of matory or other place e Cremati ce, Inc. 2. Name and Addre	on $\frac{7}{2}$	Date 24/04 J. Harte	York, PA nstein Mort lom, PA 1	17404 wary, Inc.
	Physician /Medical Examiner		23a. Han1. Enter the disease, or com- strock, or beart failure. List only Immediate Cause (Final dise is or condition resulting in death)	plications that caused the deat one cause on each line. a. Non - Hoo Due to (or as a consequence)					rrest,	Approximate Interval Between Onset and Death H Mo mhs
876ď,		cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d	,					
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous	al death 3	□Ectopic pregnanc □ Other (specify) _	′		23d. Date of de Month	livery Day Year
<u>α</u>	w requires that been signed by should be deta	þ	Part II. Other significant conditions of	contributing to death but not res	sulting in the	underlying cause giv	ren in Part I.	23e. Did t	tobacco use contribute t	o the cause of death?
Vital Records,	ysicien: The law r is certificate has be director, page 2 sh	e Completed	25. Was case referred to medical				26 Place of D	24a. Was auto perfo	ormed? death? 2 No 1 Yes	utopsy findings available completion of cause of s 2 💆 No
of	ling Ph h. After th funeral	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Injui	ner: 4 Nursing	Home 5 ☐ Resi	idence 6 Other (Spe how injury occurred	ecify)
Division	i gitt	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	fy)		me date and place	City or To	(Street and Number or Fi wn, State)	
	To the Hospital within 24 hours of To the Funerel I completely filled	Medical	(Check only 2 Medicel Exerone) 29b. Signature and title of certifier	miner: On the basis of examina and manner stated.	ation and/or i	29c. Licens	opinion, death occ se number	curred at the time,	date and place, and du	e to the cause(s)
•	15		30. Name and address of person who Dei dra C. Crews T	news, Medic completed cause of death (Ite he Johns Hopki,	m 23a) (Type	ctor RES	S-000 Northw	olfe Stre	July 21, et. Baltimor	2004 21287 e,Maryland
	St Regist	ate rar	0 dio (32. Registrar's 6ign		. Socili	٠ ١٠			

			For state	State o	f Maryla	and / Depa	artmen			and M	- 1	21	101	25060
			Registrar 1. Decedent's Name (First, Middle	, Last)			incai	J OI L	Jean		2. Date of Dea	Reg. No \	0 9	3. Time of Death
	Physicia		MADELINE ELI	ZABETH I	SAT.T.						JULY 2	Day 20	Year	10:00 PM
)	/Medic Examin		4a. Facility Name (If not institution				4b. City,	Town, or	Location o	of Death	UULI 2	10	unty of Death	
			719 FRANKLIN	AVENUE					STEF				ARROL	L
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F		rs. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt (Month, Da MAY 5	h v, Year)	9. Birth	place (State or Foreign intry)
l.	Director		218-26-3966 Usual Residence of Decedent	10 W 2X	7	4 Yrs.					MAY 5,	193	OMAR	YLAND
	land ow		10a. State 10b. County		10c.	City, Town or Lo	ocation			-				10d. Inside City Limits
	Mary -1 sh	to	MARYLAND CAR	ROLL	WE	STMINST	ER							1 ☐ Yes 2XXX0
	r 28e	Director	10e. Street and Number				10f. Zip					•	of What Cou	,
	n 72 hours atter death with the Maryland "natural", or Items 23e or 28e-1 show edical Extra free must be redified at		719 FRANKLIN A	VENUE			2	1157				UNITE	D STAT	ES
	ems erm	Funeral	11. Marital Status	12. Was Dec Armed Fo	rces?	U.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Amer Black, White	
20	hours after tural', or Ite	by Fu	1 ☐ Never Married 2 ☐ Marri 3√☐/Widowed 4 ☐ Divorced	ed 1 □ Yes If Yes, Gi Year or D	2X∏No ve		1□ Yes	No DX	Specify:					ITE
2-003p	hour		15. Decedent		ates:	16a, Dece	dent's Usua	I Occupa	ition			16h Kind	of Business/I	
ל ב ל	within 72 ene. than "nai	piet	(Specify only highes	t grade completed)	1 405 5 1	(Give	kind of wor DO NOT us	k done d e retired)	<i>uring</i> mos	t of workir	1 <i>g</i>	TOD. TUNG	J 2001110301	, addity
7	d withir giene. or than	Completed	Elementary/Secondary (0-12)	College (1-40r 5+)	SWIT	CHBOA	RD O	PERAT	OR		TE	LEPHON	TE COMPANY
and	be tiled ital Hygie id other	Bec	17. Father's Name (First, Middle,								(First, Middle,	Maiden Sui	тате)	
<u>S</u>		ို	GEORGE WILTON								BLOOM			
Mar	C1 60 - 60		19a. Informant's Name/Relationsl M. STEVEN BALL							er or Rura VOVER	/ Route Numbe	17331		ip Code)
	s 1 and if Health item 27 other tr		20a. Method of Disposition	/ BOIN	208	D. Place of Dispo	Y CIR	<u>.</u>	11141		•		ion - City or 1	Town State
altımore,	Pages nent of int: If it		1 ⊠Burial 2 ☐ Cremation		State	cemetery, crei	matory`or o	ther place		7/30 RDENS	2004			
	permit. Pages Department of Importent: If it eny injury or of		 4 □Donation 5 □ Other (S) 21. Signature of Funeral Service. 				2. Name an		i			LINN	SDUKG,	MARYLAND
ŭ	Dep Imp		Hustri K.	1 Sunt	-	\longrightarrow	YERS- 91 WI	DURB	ORAW	FUNE	RAL HON WESTM	Æ, P.	A. _{MD}	21157
			23a. Part I. Enter the disease, or shook, or heart failure. List	complications that	aused the de	eath. Do not en							., re	Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	only one cause on t	aca inte.	Acute	Rei	-21	Failur	ce .			- 4	Onset and Death
	/Medical		resulting in death)	a Due to	(or as a cons	sequence of):	100	101	1 1100				-	J 4513
	Examiner		Sequentially list conditions,	b		COION		Can	1681					Months
	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a cons	sequence of):							9	
1	xecut and	Examiner	that initiated events resulting in death) Last	c	(or as a cons	sequence of):								
8/60	death certificate be executed e attending physician and nd tor use as the burial-transit	dical E		1										
Õ	ifficate g phys as the	edic			•									
ROX	eath certific attending p	J/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pre-		∃Ectopic pr	egnancy				23d	. Date of deli	very
	s deat he att	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time o		Other (sp						Month	Day Year
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Ř	The law cate has page 2	Completed									24a. Was autor perfo	an 2 ssy rmed2	4b. Were aut prior to c death?	topsy findings available ompletion of cause of
Vital H		မ Co	25. Was case referred to medical						00 81		1 ☐ Yes	2 No	1 🗆 Yes	2 No
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Division	andin ath. or: At	atio	1 Accident 5 Pendin	gation	in ouy rous	, injury	M		Yes 2 □	No				
Ĕ	of or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could at determine	ined 288. Place	e of Injury - A ling, etc. <i>(Spe</i>	t home, farm, st ecify)	reet, factory	, office		2	28f. Location (S City or Tox		um <i>ber or R</i> u	ral Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: Atter this certifical completely illed in by the tuneral director.		20a Carifica	- Dhusisian T	- h	lea avelo de la contraction de	h	ma ab						
	24 ho Fun	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physicien: To th Examiner: On the b and man	e best of my i pasis of exam nner stated.	knowledge, deat ination and/or in	n occurred ivestigation	at the tim , in my or	ie, date an pinion, dea	id place, a ith occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	omple	Mec	29b. Signature and title of certifie	r			290	. License	number				igned (Month	
	F > F 0			pm(M	zel M	0	Addition to the state of the st	D	0059	1943	3	July	28	2004.
	10		30. Name and address of person	who completed cau	se of death (Item 23a) (Type,	Print)					1		
	1-		JOHN C. ABEL			ER AVENU	E SI	E 30	7,	WEST	MINSTEI	R, MD	21157	7
	Sta		31. Date filed (Month, Day, Year)	0 9 2004	Registrary Si	gnature	A. Carrier	1	র হ					
	Regist	EII.	5,00	0 0 2004	A Second	150 SE	8:01	1700						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2004 Merwyn Lyle Cunningham 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov 30, 19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 **3** M 2 □ F PA 1946 186-36-3037 Usual Residence of Decedent 10d. Inside City Limits Franklin CO Montgomery TWP 10c. City, Town or Location 10a. State 1 Yes 2 No Mercersburg PA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 17236 9294 Garnes Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Highway construction Heavy Equipment operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilma C. Crowe Harvey E. Cunningham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9294 GARNES RD Mercersburg, PA 17236 Joyce D. Cunningham wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) July 28, Mercersburg, PA Fairview Cemetery 22. Name and Address of Facility Miller-Bowersox Funeral Home 21. Signature of Funeral Service Licensee carette. 521 S. Washington ST Greencastle, PA 17225 23a. Part Venter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malisnant 8 month Melanoma Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a surresquence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death Check onl one 25. Was case referred to medical examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 - Homicide

Examiner Examiner been signed by the attending physicien and should be detached for use as the burial-transit law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 After this certificate has or Attending Physician: death. Director within 24 hours efter To the Funerel Dire the Hospitel

Physician /Medical

Examiner

Funeral

Director

or items 23e or 28e-1 show

"naturel",

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 Is marked other th any injury or other treumatic svent, ILIS ODGS.

Physician

/Medical

the Medical Examiner: sust be notified at

Completed by Funeral Director

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medicai þ Completed Be Certification: To Medicai

29a. Certifier

(Check only one)

State Registrar

29b. Signature and title of certifier Milamel

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

041667

75.04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCorneck

Medical Caryon Hasostown 11110

31. Date filed (Month, Day, Year)

32. Recentrar's Signature AUG 0 9 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Year Month 3:00 PM **Physician** JULY 2004 30 Colbert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Lanham Doctors Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb 16, 7. Age (In yrs. last birthday) 5. Social Security Number Funeral **№** M 2□ F Yrs. Director 92 <u> 214-05-6554</u> 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show treumatic event, the Medical Examiner must be notified at Yes 2 No Cumberland Allegany MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 34 Grand Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1. ∏Yes 2. □No INVes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Railway Maint./Carpenter 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia (Slippey) Colbert Winfield Scott Colbert 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Pages 1 and 2 s ment of Health an College Park MD 20740 Vernon Poole Sr. 9018 Autoville Drive nephew If item 27 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ö 8/3/2004 permit. Page Department of Important: If any injury or once. Rocky Gap Veterans' Cemetery MD Flintstone 4 Donation 5 Other (Specify) 21. Signature of Funeral/Service Licensee 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician PNEUMONIA disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner RENAL FAILURE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit The law requires that the death certificate be executed HYPER KALEMIA Due to (or as a consequence of) that initiated events resulting in death) Last attending physician DAYIS Physician/Medical IF FEMALE P.O. Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 Yes 2 No 3 Probably 4 DUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy perform 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide n 24 hour. the Funeral P 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 To the

State Registrar

29b. Signature and the of certifier

31. Date filed (Month, Day, Year)

PARAND

Jarand Maw IND

ALAVI, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 0 9 2004

Melvin

DHMH 17 Rev 1/2001

ORIGINAL

8118 GOOD LUCK

32. Registrar's Signature

29c. License number

LANHAM, MO

D0058275

29d. Date signed (Month, Day, Year)

7-30-04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Karen Lee Currin For Unpend Item #23a, pt. II, 27 per me C835 9704 tas

Registrar Certificate of Death

Reg. No. 04 - 4819AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:30 A July 25, 2004 Karen Lee Currin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours | Min. | Jan 25 19 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1□ M 2X F Months 48 Yrs. Director Wisconsin 390-62-8343 Isual Residence of Decedent Manyland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f show the Medical Examiner nest be notified at 1 ☐ Yes 2 XNo Director Maryland Washington Hagerstown 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 12022 Heather Drive U.S.A. Івтя 23а Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within : h and Mental Hygiene. 7 Is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) Rehabilitation Assistant Assisted Living Facility 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 0 Gordon Ammon Pat Sapotta Ammon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s nent of Health an ent: If item 27 Is Keith A. Currin / Husband 12022 Heather Drive Hagerstown, Maryland 21740 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any injury of once. * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory July 28, 04 Smithsburg Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the burial-transit The law requires that the death certiticate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ò in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Asthma, Obesity, Hypertension 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2□ No 2□ No of Vital Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Hospital or Attanding Injury 1X Natural after death. 1 ☐ Yes 2 ☐ No Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 - Homicide within 24 hours a To tha Funaral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 O.C.M.E. July 27, 2004 eath (Item 23a) (Type, Print) Name and address of perso who completed cause of KOLLAK 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar Signature State AUG 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			,	State of Marylai	-		of Health and l of Death	-	giene Reg. No. 0 0 4	25064
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Ye	3. Time of Death
	/Medic		YONG SOOK CHONG					JULY	12, 2004	7:30 AM
	Examin Funeral Director	ier	4a. Facility Name (If not institution, give str 7615 FOXTRAIL CT. 5. Social Security Number 576-78-3303	reef and number) 7. Age (In yrs	-	if Under 1 Y	4b. City, Town, or HANOVEI (ear If Under 24 Hrs ays Hours Min.	8. Date of Bir	ANNE A	ARUNDEL Birthplace (State or Foreign Country)
			Usual Residence of Decedent					NOV. 15,	1919	KOREA
	nylen show		10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	8a-f s	Director	MD ANNE ARUN	DEL	HANOVER					1 ☐ Yes 2 ☑ No
	with the	훕	10e. Street and Number			10f. Zip Co			10g. Citizen of What	Country?
	eeth	eral	7615 FOXTRAIL CT. 11. Marital Status 12	. Was Decedent Ever in U	IS 13 1		076 of Hispanic Origin? (S	necify Ves or No	USA	merican Indian,
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	1 end Health em 27 thar t		MIMI CHONG (D	AUGHTER)	7615 Place of Dispo		AIL CT., H	ANOVER,	MD 21076 20c. Location - City	or Town State
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Vital Records,	aw requires to been so	Completed by						24a. Was perfo	an autopsy 24 ormed?	b. Were autopsy findings available prior to completion of cause of death?
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₹	Physician: The this certificete	Be c	25. Was case referred to medical examiner?	spital:			Othor	ath (Check only		
o	ding Phys h. After this funeral di	tlon: To	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No		dence 6 Other (S	pecify)
Division	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, str ify)			28f. Location (City or To		Rural Route Number,
	ha Hospital in 24 hours he Funeral pietely filled	edical	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examina	ian: To the best of my known to the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the vestigation, in	ne time, date and place my opinion, death occu	e, and due to the arred at the time,	cause(s) and manner date and place, and	as stated. due to the cause(s)
	Vithii To th	Ň	29b. Signature and title of certifier	111		29c. Li	cense number		29d. Date signed (M	onth, Day, Year)
				10			121654		7/14/0	4
2	-2/		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type,	Print)	VV	GB	mo 2	126/
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature					

DHMH 16 Rev 6/95

	an	1. Decedent's Name (First, Middle, Last)	#7&8 PER FH G83408		2. Date of Death Month	Day Year	3. Time of Death
/Medic	al	Evelyn June Dozie 4a. Facility Name (If not institution, give si		4b. City, Town, or Location of Death	July	4c. County of Deat	
Examin	er	Washington County		Hagerstown		Washingto	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y	-07-37 o Big	thplace (State or Foreig
Director		233-56-3222	M 2XXF 65 67 Yrs.	Months Days Hours Min.	Jan. 7, 19	39 W	ountry)
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and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Modical Examiner must be notified at	၉	George Warner Dozi			irginia T		
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Department in Importent: If eny injury of once.		21. Signature of Funeral Service-License					g, wv
Per gua		Chale M Blog	Je De	22 Name and Address of Facility efferson Chapel Fur D Box 838, Charles	neral Homo	e 25414	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest		Approximate Interval Between
nysician		Immediate Cause (Final disease or condition		Homorphia			Onset and Death
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			Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physici: /Medic		Paul Samuel Ebersole		July	22 2004	2350 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death	1
			Washington Conunty Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Hagerstown			gton Count
	Funeral		1X M 2 □ F \ 7.7 yr		(Month, Day,	Year) Cou	nplace (State or Foreign untry)
	Director		162-22-0834 Usual Residence of Decedent		Oct 26	1926 Penn	sylvania
	yland 10w		10a. State 10b. County 10c. City, Town of	Location		-	10d. Inside City Limits
	Mar st	tor	Maryland Washington Clear	Spring			1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
	23a	rai	13548 Cresspond Road	21722		U.S.A.	
	tams	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 M No If Yes, Give 3 1 Wildowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Medical Examinar mail termulified at	edt	15 Decedent's Education 16a D	acedent's Usual Occupation	1	6b. Kind of Business/I	Industry
15	on " on	Completed	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	ive kind of work done during most of wo e. DO NOT use retired)	rking		·
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힏	al Hy l othe	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, M		
Maryland	Ment Ment arked	ဂ္	Harry L. Ebersole	Rose	tta M. Wa	del	
ar	2 sho and lam raum			ailing Address (Street and Number or R			
<u>2</u>	s 1 and 2 of Health a Itam 27 is			124 Greencastle Pi		stown Mary 20c. Location - City or	
0	ges it of H if Ita		1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	crematory or other place)			
Baltimore,	t. Pa rtmer rtant:					Hagerstow	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Itam 27 is marked othar than "natural", or Itams 23a or 28a-f show any injury or othar traumatic event, the Medical Examinat must be rutilized at Once.		21. Signature of Funeral Service Licensee	.0	_	Fiery Fun	
			23a. Part1. Enter the disease, or complications that caused the death. Do no	1331 Eastern Blvd. enter the mode of dving, such as cardia			Approximate
	Dharatatan		shock, or heart failure. List only one cause on each line.	Troma			Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of)	90001111			Danys
	Examiner		15 (18 211 B)	Cardio Myona	tt	-	5 thank
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9 ×	death certifical e attending phy d for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			601.5	
Вох	attend for us	lan	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
o.	he de the	ysic	1 Yes 2 No 9 Unknown	5 Curier (specify)			
α.	res that the de igned by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires n sigr	d by			1 ☐ Ye	s 2 No 3 Pro	obably 4 Unknown
Vital Records,	law requires as been sign 2 should be	Completed			24a. Was ar		topsy findings available
Re	o - g	mo			autopsy perform	ned? prior to death?	completion of cause of
ta	ilclan: Th certificate rector, pag	0	25. Was case referred to meetical	26. Place of De	ath (Check only one		26.140
>	tending Physician: leath. tor: After this certific the funeral director,	To B	examiner? 1 Yes 2 FR/Outp	atient 3 DOA Other: 4 Nursing	Home 5 Reside	nce 6 Other (Spec	city)
n of			27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury		28d. Describe ho	w injury occurred	
Sio	Attending r death.	atle	2 Accident investigation	M 1 Yes 2 No			
Division	l or Attendation of the death of the Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Str City or Town	reet and Number or Ru i, State)	ral Route Number,
	urs al	O					
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edlcai	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and manner as ate and place, and due	to the cause(s)
	o tha ithin 2 o tha	Mec	29b. Signature and title of certifier	29c. License number	29	9d. Date signed (Monti	h, Day, Year)
	F ≯ F ŏ		Amuel (haw mi)	1 36655		014 23	1 700U
	10		30. Name and address of person who completed cause of death (trans, 23a) or	Print ^	111	-	
	Ψ		304 East ANTIGTON SING	· m/e 200. /	Hausta	ur, MD	21740
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1. /	1		
	Regist	rar	AUG 0 9 2004	H. Aparles .			

		1 - State Registrar	Amend						ificate of				giene	04	25067	
cia	an	1. Decedent's Na	me (First, Mic	ddle, Las	t)						2	. Date of De Month	eath Day	Year	3. Time of Death	
ic	al	Crystal 4a. Facility Name	(If not institut	tion, aive	street and n	um ber)	Fette		4b. City, Town,	or Location		July_	29 4c. Cour	2004 nty of Death	10:22 P	
n	er	Cumber:					ıl		Cumb∈					llegan	У	
		5. Social Security 216-86 Usual Residence	-6585	6. Se	ex □ M 21√ F	7. Age (1	In yrs. last t	birthday)_ Yrs.	If Under 1 Year Months Days		Min.	Pate of Bi (Month, P. Feb 1	7, 1976	9. Birthpl Coun	ace (State or Foreig	
	tor	10a. State	10b. Cour	egar	ny	1	Oc. City, To		erland			-		11	0d. Inside City Limits	
	Funeral Director	10e. Street and N		ry Av	enue				10f. Zip Code	2150	2		10g. Citizen	of What Coun	try?	
	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced			12. Was De Armed F 1 Yes If Yes, G	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		13. Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerton 1 Yes 2 No Specify:				(Specify Yes or No- arto Rican, etc.) 14. Rac Blac		lack, White,	ce - American Indian, ack, White, etc.	
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		19a. Informant's				ather		1201	Address (Stree 2 Mulbe		enue	Cum	ber, City or Tov berland		^{Code)} 21502	
			isposition 2 Crematic n 5 Other			n State	ceme	etery, crem	ition (Name of atory or other pla orial Park		Da 8	te /2/2004		n - City or To perland		
	1		Funeral Servi				1/0				ility					
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		State of Maryland / Department of Health and M Certificate of Death	Mental Hygiene
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	/Medical Examiner	45 City Town or C	
	Examine		oring Montgomory
	Funeral	5. Social Security Number 6. Sex 7. Age (In vrs. lest birthdey) If Under 1 Year If Under 24 Hrs.	oring Montgomery 8. Date of Birth Gountry 9. Birthplace (State or Foreign Country)
н	Director	325-46-0055 1□M 2気F 54 Yrs. Months Days Hours Min.	3/21/1950 Georgia
	D	Usuel Residence of Decedent	
	word.	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	a was	MD P.G. Laurel	X Yes 2 No
	in the	10e. Street and Number	10g. Citizen of What Country?
-	led within 72 hours after death with the Marylend ygiene. The second is not seen as a critical show it, the Medical Examinations to profited at the market has Eumanal Director.	9637 Muirkirk RD. 20708	U.S.A.
	ama di	11. Marital Status 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (Spr. Armed Forces? 14. Was Decedent of Hispanic Origin? (Spr. Armed Forces?)	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
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т.	00 = 0 G	Anne Eduluds 3910 Silver Hill	1 RD.Suitland, MD.
	4	23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line.	Interval Between
	Physician		Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition a. End Stage HIV	
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\leq	i beferecuted siclen end i bunel-trensit	Sequentially list conditions, If any leading to immediate	
88760	clen clen burie	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):	
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Box	requires that the deeth certificeen signed by the attending thould be datached for use as		
0	that the dended by the a datached to Dhyelo	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
Ω.	d by	Malnutrition	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
18,	signe Id be d		24b Word autonou findings
Record	Tha lew requir		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
ec	a lew has b		of death?
=	icata he		1 ☐ Yes 2 ☐XNo 1 ☐ Yes 2 ☐ No
Vital	Physician: this certific rel director,	25. Was case referred to medical axaminer?	h (Check only one)
of	this or	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
	After the funere	27. Manner of Death 28a. Date of Injury 28b. Time of Injury et Work?	28d. Describe how injury occurred
<u>Si</u>	Attending in deeth. octor: After by the fune	2 Accident investigetion 3 Suicide 6 Could not be	
Division	tal or Attending P rs aftar deeth. al Director: After t led in by the funers	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
	n 24 hours in 24 hours pletely filled	29a. Certifier (Check only Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred.	
	within 24 To the F complete		
	with To the	16:	29d. Date signed (Month, Day, Yeer)
	1.	Saima Charrage D0058965	July 29, 2004
	4	30. Name end eddress of person who completed cause of death (Item 28a) (Type, Print)	
		Saima Khawaja MD 11119 Rockville, Pike Ste. 100	Rockville,Md.20852
	State Registrar	151日~17日日 利。 2a 2 a 7 a	
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DHMH 16 Rev 6/95

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 1, 2004 **Physician** 0:05 PM Thomas Paul Franciosi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lions Manor Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 28, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-18-4600 MD 82 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County or Items 23a or 28e-f show other treumatic event, the Madical Examiner must be notified at MD Allegany Cumberland 1, Yes 2 No Director ranciosi, Thomas 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 724 Hilltop Drive 21502 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2 No Specify: white 3 Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) supervisor Macaroni Factory 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Valentine Franciosi Adeline Carpenti Franciosi 19a. Informant's Name/Relationship (Type, Print)
Mary Sweitzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Cresap Knoll Apt C Cumberland MD 21502 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 7/30/2004 Cumberland MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licenses 108 Virginia Avenue: Cumberland, MD 21502 23a. Pard. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Physician 5 minuter /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial tran Due to (or as a consequence of): Division of Vítal Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Alzheimors 1 Yes 2 No 3 Probably 4 Unknown disease. 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy this certificate 1 Yes 21 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other 4 ursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No ₹ Director: After the in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 29, 200 4 00055325 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tarm Terrace Frostburg MD21532 MONSOCK SHIN MD 31. Date filed (Month, Day, Year) AUG 0 9 2004 32 Aegistrar's Signature State Registrar

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	5.		Registrar 1. Decedent's Name (First, Middle, Li	astl	Ce	rincate of D		Reg. No.	UUL	3. Time of Death
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>	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or L			County of Death	0.10 1
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	Funeral		5. Social Security Number 6.		(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year)	9. Birthp Cour	lace (State or Foreign
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	r 28s	rec	10e. Street and Number		11000110	10f. Zip Code		10g. Cit	izen of What Cour	ntry?
	h with	al D	6006 Linganore Ro	ad		21701			U.S.A.	
	ems serve	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Specif , Mexican, Puerto Ric	y Yes or No-	14. Race - Americ Black, White,	
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yla	2 should be n and Mental is marked o raumatic eve	ဥ	Louis Furi				Sadie	Go1d		
Maryland	12 sh n and ris m		19a. Informant's Name/Relationship			ing Address (Street ar				
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Heatih and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		Wendy Sue Furie/	Daughter	20b. Place of Disp	Linganore	Koad, Fre		laryland, ocation - City or To	
altimore,	permit. Pages 1 Department of H Important: If ite any injury or otl		1 ☐ Burial 2 Tremation 3		cemetery, cre	matory or other place				
Ħ	artme ortani injury	. 1	* 4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice			rg Cremato 2. Name and Address		, 2004 Sml		Church St.
B	Dep Imp any		P. Ryan Ti	nº Millian) K	eeney and Bas	sford P.A. F	uneral Home		k, MD, 21701
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Вох	death certifi e attending p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes. outcome 1 ☐ Live birth		☐Ectopic pregnancy			23d. Date of deliv	
Ö.	0 00 0	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)			WOITH	Day Year
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<u> </u>	S S	OB	examiner? 1 🗆 Yes 2 🔁 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatio	ent 3 DOA Othe		5 Residence	6 ☐Other (Speci	(y)
0 4	ng Ph ter th neral	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Da)	y Year) 28b. Time	of 28c. Injury Work	at 28	d. Describe how inju	ry occurred	
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Division of Vital Records,	or Att fter d direct in by i	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, s c. (Specify)	treet, factory, office	28	f. Location (Street ar City or Town, State		al Route Number,
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying 1 (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examination and/or	nvestigation, in my op	inion, death occurred	at the time, date an	d place, and due t	o the cause(s)
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DHMH 17 Rev 1/2001

ORIGINAL

Physician /Medical Examiner or Attending Physiclen: The law requires that the death certificate be executed use as the burial-transit and Box 68760, physician been signed by the atte should be detached for Division of Vital Records, P.O. ģ page 2 certificate After thi funeral within 24 hours efter death. To the Funeral Director: A completely filled in by the fu To the Hospitel

Funeral

Director

23a or 28a-f show

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permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Importent: If Item 27 le marked other the any injury or other traumatic avent, Item 2000.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Medicul Exerciner must be notified at

Examiner Certification: To Be Completed by Physician/Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 28. DOC 33280

625 KENT

32. Registrar's agnature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gupta

AUG 0 9 200%

Surice 31. Date filed (Month, Day, Year)

State Registrar

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Avenue Combertano.

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Jul 30, 2004 **Physician** Ethel Grapes 05:12 am ^м /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany County Nursing Home Cumberland Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Month Day. Oct 10, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F 216-22-5162 85 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County in than "natural", or frems 23s or 28s-f show the Medical Examiner must be notified at Allegany Cumberland 1 □Xes 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 Glenwood Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien important: if item 27 is marked other than any injury or other traumatic event, Italy pres. waitress Anton's Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irvin Ketterman Marjorie Sponaugle Ketterman 19a Informant's Name/Relationship (Type, Print)
Robert Sowers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Seymour Street Cumberland MD 21502 son 20a. Method of Disposition

1 Deurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunset Memorial Park Date 20c. Location - City or Town, State 8/2/2004 MD Cumberland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Namscantellispunella Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ONE 92 /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 1 ☐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter deal To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0-14865 30. Name and address of person who pleted cause of death (Item (1) Type, Print) Mem. Hosp Med Bldg Cumberland MD 21502 Robustiano Barrera M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

	5	*	For State Registrar	State o	f Marylan		artment			ınd M	lental Hyg R	iene .g. N2 () (25076
	Physici	an	1. Decedent's Name (First, Middle								2. Date of Dear Month	Day	Year	3. Time of Death
,	/Medic	al	4a. Facility Name (If not institution		tty Jane Ki	ıng	4h City	Town or	Location o	f Death	Augi	1st 01, 20		4:20 P. M
	Examin	er		1246 Cunning			40. Oity,	TOWN, OF		umbe	rland	10. 000		
Т	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under		If Under a	24 Hrs.	8. Date of Birth	Voor)	Allegany 9. Birthplace (State or Country) Pennsylvar 10d. Inside City 1	place (State or Foreign
	Director		272-26-7933	1 □ M 2 1 F	73	Yrs.	Months	Days	Hours	Min.	(Month, Day March 1			Pennsylvania
	P .		Usual Residence of Decedent		140.0									
	arylar show	-	10a. State 10b. County		100. 0	ty, Town or Lo	ocation							1 ☐ Yes 2 ☑ No
	38-f	Director		Allegany					Cumber	rland				
	filed within 72 hours after deeth with the Maryland Hygiene. other than "naturel", or Itams 23e or 28e-f show ont, the Medical Evantiner must be notilied at		10e. Street and Number	0 1	D :		10f. Zip	Code	2150		1	log. Citizen of		•
	s 236	Funeral		Cunningham	Drive edent Ever in U	10 12	Was Doord	ont of Hi	2150		noifu Vas as Na	14 Ra		
	ter de Itam	Ë	11. Marital Status 1 □ Never Married 2 Marri	Armed Fo	orces?	7.3.	If Yes, spec	ify Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)			
38	urs af	b	3 ☐ Widowed 4 ☐ Divorced	If Vas Gi	ve ates:		1□Yes 2	No.	Specify:			Spec	ify:	White
ĕ	2 hou	ed	15. Deceden	it's Education		16a. Dece	dent's Usua	(Occupa	ation			16b. Kind of I	Business/l	
215	hin 7.	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of wor DO NOT us	k done d e retired	turing most)	or worki	ng			
2	gient er the	Ö	8		0			Sa	ales Cle	rk			Clo	thing
힏	al Hy H oth	Be (17. Father's Name (First, Middle,						18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)	
<u>ya</u>	Ment Ment arke	2		Henry L	ynch							Margaret	-	
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relations		1	19b. Maili	•							
	l and deelth am 27 ther t		William Dale	King - Husba		Place of Dispo			unning		orive, Cum			
0	in the state of th		20a. Method of Disposition 1 KBurial 2 Cremation		1 .	cemetery, cre	matory or of	ther plac	* 1		August 03,			
Baltimore,	t. Pa rtmen rtent:		`4 ☐ Donation 5 ☐ Other (S				irg Mem		- 1		2004			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene Department of Heelth and Mental Hygiene Winportent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Evarities must be notified at once.	l onacon										D 21539	8 East 1	Main Street
8760,	bhysician and hysician and hysician and the bruial-transit	licai Examiner	23a. Part . Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	(or as a consection as a conse	quence of):	1				- with o		destro	Interval Batween Onset and Death
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ita	stcian: The certificate rector, pag	Bec	25. Was case referred to medica examiner?	ıl					26. Place	of Death	(Check only or	-		
Ž >	Physic this ce al dire	P P	1 ☐ Yes 2 No			ER/Outpatie		-	4 🗆 140	rsing Ho	me 5 ∑ Resid	ence 6 🗆 O	ther (Spec	ify)
o nc	tending Physician: The leath. tor: Atter this certificate hatte funeral director, page		27. Manner of Death 1 Natural 5 □ Pendi		of Injury oth, Day Year)	28b. Time of Injury	of 2	8c. Injun Worl	/at <br Yes 2 🔲 I		28d. Describe h	ow injury occu	irred	
Division of Vital Records,	I or Attending Physician: after death. Diractor: After this certifical I in by the funeral director.	Certification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	nined 200. Flac	e of Injury - At h ling, etc. (Speci	nome, farm, st			163 201		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rui	ral Route Number,
	Hospite 4 hours Funerel ely fillec	edical C	29a. Certifier 1 A Certifyi (Check only 2 Medicel	ng Physicien: To th Exeminer: On the l and mai	e best of my knoosis of examination	owledge, deal ation and/or in	th occurred a	at the tin	ne, date an pinion, dea	d place, th occurr	and due to the cred at the time, c	ause(s) and n late and place	nanner as , and due	stated. to the cause(s)
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	\wedge		30. Name and address of person	who completed cau	se of death (Ite	Ga) (Type	Print)	IJ		/-		U	10	/ 0 /
	0		Thomas	E Cha	18/1	1 140	9/2	7	50/	2 L	- Cum	corken	do	10 21507
	St: Regist		31. Date filed (Month, Day, Year	UG 0 9 20	Registrar's Sign		# 1	bes	٠ آو ي					-

			S	tate of Maryland /	Department of F			ene	1, 25	075
			1. Decedent's Name (First, Middle, Last)				2. Date of Death	1		me of Death
	Physici	an		T a alterna a d			Month	Day 5, 2004	Year 10	:20 A.M.
	_/Medic		Sister Clementine 4a Facility Name (If not institution, give stre			4b. City, Town, or Lo		4c. County of		.20 A.III.
j.	Examin	er				Emmitsb	ıro	Fred	erick	
			St. Vincent Care 5. Social Security Number 6. Sex	7. Age (In yrs. last	hirthday) If Under 1 Year		8. Date of Birth (Month, Day,		9. Birthplace (S Country)	tate or Foreign
	Funeral Director		1□ M	2☑ F	Yrs. Months Days	Hours Min.	(Month, Day, Oct. 22	Υθα <i>r</i>) 1910		ton,D.C.
		1	379-52-9532 Usual Residence of Decedent	93			000. 22	1710	Masmins	2011,2.0.
	er end	ı	10a. State 10b. County	10c. City, To	own or Location		-		10d. Insi	ide City Limits
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	ath with the Marylen 23a or 28a-f show ust be notified at	Director	10e. Street and Number	C Emmi	10f, Zip Code		10	g. Citizen of WI	hat Country?	
	wit with		225 C		2172	7		TT C A		
	Peath	Funeral	335 South Seton A	Was Decedent Ever in U,S.	2172 13. Was Decedent of H	lispanic Origin? (Spe	ecify Yes or No-		- American Indi	an,
	urs efter dea al', or itame Examiner m	Ē	1⊠ Never Married 2□ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		an, Mexican, Puerto	Hican, etc.)	Black	, White, etc.	
220	Ir, or	ğ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 反 No	Specify:		Specify:	White	
21215-0020	72 hours efter death with the Maryland natural', or itama 23a or 28a-f show dical Examiner must be notified at	B	15. Decedent's Educati		6a. Decedent's Usual Occup	pation		16b. Kind of Bus	iness/Industry	
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au	should be filed and Mental Hygi marked other imatic evant, I	To B	William Edward Lo	rkwood		Marie '	Theresa	Gillen		
Maryland	d 2 should th and Men 7 Is marke traumatic	-	19a. Informant's Name/Relationship (Type,		9b. Mailing Address (Street				State, Zip Code)	
Ĭ	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		Sister Camilla Ha	cont	333 S. Seto	n Avenue	Emmitch	ure MD	21727	
ē,	- 7 5 5	ŀ	20a. Method of Disposition	20b. Place	of Disposition (Name of		Date 2	20c. Location - C	City or Town, Sta	ate
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Bal	permit. Par Departmen Important: any injury		21. Signature of Purieral Service Licensee	1.6.		or	CILES FU			
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			23a. Part. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the death. Deause on each line.	o not enter the mode of dyir	ng, such as cardiac o	or respiratory arre	est,	Interv	ximate al Between : and Death
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	LAdillilei	ايا	resulting in death)	Due to (or as	a consequence d):	1.	1		11	. 4
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	law requires thet the death certifi as been signed by the attending t 2 should be detached for use as	Physician/M	Part II. Other significant conditions contrib	uting to death but not resulting	g in the underlying cause giv	ven in Part I	23b. Did to	bacco use conf	tributa to tha ca	ause of death?
P.0	res thet the designed by the a	£	(Vttoernales	to Carol	innerall	A. Deso	1 □ Y	s 2∏ No	3 Probably	4 🗆 Unknown
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æ	The is ete ha page	E	Parken	Som			1 □ Ye	s 2 🔯 No	1 🗆 Yes	2][] No
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ō	Phy or this eral o			28a. Date of Injury 28	b. Time of 28c. Inju		28d. Describe ho			
o	ding th. : Afte	Iţo	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		Yes 2 No				
Division	Attending I st death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home	, farm, street, factory, office		28f. Location (St	reet and Numbe	r or Rural Route	Number,
Ö	or / efter Dire	ert	4 ☐ Homicide	building, etc. (Specify)			City or Towr	i, State)		
_	spits ours neral		29a. Certifier 1 Certifying Physici	an: To the best of my knowled	dge, death occurred at the ti	me, date and place,	and due to the ca	ause(s) and mar	ner as stated.	
	To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	(Check only 2 Madical Examinar one)	On the basis of examination and mamner stated.	and/or investigation, in my	opinion, death occur	ed at the time, d	ate and place, a	nd due to the ca	iuse(s)
	ompl	Me	29b. Signature and title of certifier		29c. Licens	se number	2	9d. Date signed	(Month, Day, Y	ear)
	- 5 - 0) / // \a	1 ALLIA	INW \ I	11810		JULY 26	, 2004	
	1	-	20 Name and sides of the same	ploted cause of dooth (from 20	ta) (Type Print)	10/0.			-	
	(30. Name and address of person who comp			/***********	VD 015	27 (
			ALAN CARROLL, M 31. Date filed (Month, Day, Year)	D 310 S SE		MITSBURG,	MD. 217	41		
	Sta	ite	ALIC O		K houts	NOT -				

DHMH 16 Rav 6/95

	T.		For State Registrar	State of Ma	aryland / Depa	artment of F		d Menta		201	04	250.76
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)				2. Dat	te of Death	Day	Year	3. Time of Death
	Physici: /Medic			Lewis				JUI			004	5:50P. M
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			15 S.ROGERS STREE		on (In very land high days)	ABER	DEEN If Under 24	Hrs le Day	o of Righ	HARFU	year 004 5:50 of Death RD 9. Birthplece (State Country) Germany 10d. Inside Pare American Indian, k, White, etc. White usiness/Industry The State, Zip Code) Thany City or Town, State PA Approxim Interval B Onset and Onset and Approximoustry The The of delivery Interval B Onset and Approximoustry The of delivery Interval B Onset and Approximoustry The of delivery Interval B Onset and Approximoustry The of delivery Interval B Onset and Approximoustry The of Code The of Gelivery Interval B Onset and Approximoustry The of Code The of delivery Interval B Onset and Approximoustry The of delivery Interval B Onset and Approximoustry The of delivery Interval B Onset and Approximoustry The of Code The of C	bloom (State or Foreign
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			Usual Residence of Decedent		0.5			1.43	107	1521		marry
	yland		10a. State 10b. County		10c. City, Town or Lo	cation					1	0d. Inside City Limits
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	ath w	-a	15 S. Rogers St		5	2100		0.40 14 14				
	tem item	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☒	'	Was Decedent of H If Yes, specify Cuba	an, Mexican, F	uerto Rican,	etc.)			
36	irs aff	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:			Specia	^{ŕy:} Whi	.te
21215-0036	72 hours after death with the Maryland naturel', or Items 23s or 28s-1 show deal Examinat rust bu notified at	Completed by Funeral Director	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	f washing	16	6b. Kind of B	Business/In	dustry
218	within 7 ene. then "n	ple	(Specify only highest gi	College (1-4or	5+)	kind of work done DO NOT use retired	during masi a d)	working				
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Maryland	should be filed within and Mental Hygiene. s marked other then "sumatic event, it e Men	To Be	17. Father's Name (First, Middle, Las Anton Sigmund	t)				alena (First,		iiden Sumai	me)	
_	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene them 23a or 28a-1 show tem 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	•	19a. Informant's Name/Relationship Ingrid Bartsch		19b. Maili 95030							
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other tra <u>9068</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Other (Specific Specific		20b. Place of Disponsion Report Repor	matory or other plac		Date /2/04			-	
Balti	permit. Departm Importe any inju		21. Signature of Funeral Service Lice	ollma	larring-C Aberdeen,	argo Facility Maryla	neral and 2	Home,	P.A. 3399			
8760,	Physician be executed attending physician and attending physician and for use as the burial-transit	ilcal Examiner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a consequence of):	atic (ardi) Video	Le-	Dis	ease	Inferval Between Onset and Death
.O. Box 6	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 25 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	у					*
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Records,	e law has b	Completed					-	24		ed?	prior to co	mpletion of cause of
Vital	Phyeiclen: Th this certificete ral director, pag	Be (25. Was case referred to medical examiner?	1				Death (Chec	ck anly ane,)		
of\	di Si	ပ္	1 XYes 2 No	Hospital: 1 Inpati		III 3 DOA	A CAMP TOWN					SCENE
'n		lo	27. Manner of Death Natural 5 Pending	28a. Date of Inj (Month, Da	ury 28b. Time o ay Year) Injury	Wo	ryau rk? Yes 2.⊟No		escribe now	injury occu	rred	
Division	or Attending fler death. Jirector: After in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	ijury - At home, farm, st tc. (Specify)		1103 2 110	28f. Lo	cation (Stre ty or Town,	et and Num State)	ber or Rura	al Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical Ce	(Check Check 2 Medical Ex	aminer: On the basis of	of examination and/or in							
	thin 2 thin 2 the mplet	Med	29b. Signature and title of certifier	and manner s	tated.	29c. Licens	se number		290	d. Date sign	ed (Month	Dev. Yeari
	5 × × ×			O MIN			C.M.E.					7/
	1		2011	a completed source of	death (Item 23a) (Type		C.M.E.		00		, 2004	
	Y		30. Name and address of person wh	te and			Street	, Balt	imore	, Mary	yland	21201
	St Regist	ate rar	AUG 0 9 20	104 3	J. So	who .						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** A^{M} July 24 2004 0227 Charles H. Mangold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Hospital Cecil | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 25, 1 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 1918 Director 221-09-1432 86 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or flems 23s or 28e-1 show traumatic event, the Medical Examiner must be multilled at 1 ☐ Yes 2 No by Funeral Director Newark Delaware New Castle 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19702 59 Egret Court United States 12. Was Decedent Ever in U.S. Armed Forces? 10/13_ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1943-XYes 2 No 1945 f Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic/Truck Driver Chemical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennie Andryaitis John Mangold 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health 52 Curtis Lane, Colora, Maryland 21917 Ada J. Henderson/Sister other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Siloam United Methodist Church Cemetery July 28, Boothwyn, Ponnsylvania 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. *4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Facility
Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses overd 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Bradycardia Sudden **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Y EGNS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COLOHALY Due to (or as a cons dence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?
1 Yes 2 No
9 Unknown Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Ýes 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate 1 🗌 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To atient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Feath ate of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending after death.

Director: Af 1 Tyes 2 No investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by 4 Homicide within 24 hours after To the Funerel Dire filled 1 Sestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 27, 2004 D0055190 ress of person who completed cause of death (Item 23a) (Type, Print) Hospital 106 Bow St Elector MD Vyron MO 32. Registar's Signature State Registrar

			1 - For Amend Item 2. Registrar	State of Ma Ba per Dr	rylan ••G8	d / Depart 34,08/0 9	ment of l 104dhb icate of	lealth an <i>Death</i>				00 h	250	79
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)		Mo	icias			ر	Date of Dea Month	Day	420	1450	Death P M
>	Examin		4a. Facility Name (If not institution, give s Shady Grove	Adventi	st H	ospital	Rock	kville			M	ounty of D	omery	
	Funeral Director		213-23-7041	M 2□F	e (In yrs.	N	Under 1 Year onths Days		Min.	Date of Birt (Month, Da ct. 21,	v, Year)		Birthplace (State or Country) Bolivia	r Foreign
	the Maryland 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo: 10e. Street and Number	mery	10c. Cit	y, Town or Locat Gaithei					10g. Citiz	en of What	10d. Inside Cit 1 ☐ Yes t Country?	,
36	be filed within 72 hours after death with the Maryland ital Hygiene dother than "neturel", or items 23e or 28e-f show event, it is Marical Exporter front the notified at	by Funeral Di	12 Orchard Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 200 If Yes, Give Year or Dates:			208 s Decedent of less, specify Cub	Hispanic Origin ban, Mexican, P		y Yes or No- an, etc.)	- 1	4. Race - A	States Imerican Indian, Vhite, etc. White	
31215-0036	filed within 72 hour Hygiene. other than "neturel ent, tre Mullad Er	Completed t	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e com <i>pleted)</i> College (1-4or 5	+)	life. DO	d of work done NOT use retire	during most of ed)	f working				ess/Industry	
Maryland 21	should be filed within 72 hours nd Mental Hygiene. I marked other than "neturel", umatic event, it e Madical Exu	To Be Cor	17. Father's Name (First, Middle, Last) Juan Macias	3		Teache	r/Music	18. Mother's		First, Middle,	Maiden	gh Sch Sumame)	1001	
	1 and 2 shou Health and M Iem 27 is mar other treumat		19a. Informant's Name/Relationship (Ty. Carlos Macias/Son	pe, <i>Print</i>)	20h F	5 Orcha	ard Dri	ve, Gai		sburg	, Mar	yland		
Baltimore,	permit. Pages 1 and 2 should I Department of Health and Men Importent: If item 27 is marke eny injury or other treumatic once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service ☐ Censul	90		Roc Roc	al Parl ame and Addr kville	ess of Facility	uly (2004 Robe 300	rt A. West M	R Pump lonte	ockvi hrey omery	11e,Maryl Funeral I Avenue	and Home,
ļĪ	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused ne cause on each lin	ne.	h. Do not enter the nemotion of):	ne mode of dy	ge	rdiac or r				Approximate Interval Beth Onset and D	veen Death
760,	e be executed /sician and e burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as	a conseq	,	scular	Accide	nt				06/30/20	004
O. Box 68	death certific e attending p id for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	il death 3□Ed	topic pregnand ther (specify) _	су			2	3d. Date of Month		'ear
ds, P.	uires that the signed by ald be detacted.	by	Part II. Other significant conditions con	ntributing to death b	ut not res	ulting in the unde	erlying cause g	iven in Part I.			obacco u Yes 21		te to the cause of d	
Records,	The law requires that the site has been signed by the page 2 should be detache	Completed							-	24a. Was autor perfo 1 Yes		prior deat	e autopsy findings a to completion of ca h? Yes 2 \(\square\) No	available ause of
ita	Physicien: r this certifica ral director, p	Be (25. Was case referred to medical examiner?						f Death (Check only o	ие)			
2	nysic nis ce dire	Tol	1 ☐ Yes 2 ☐ No	lospital: 1 Inpatie	ent 2	ER/Outpatient	3□ DOA O	ther: 4 🗌 Nursi	ing Home	5 ☐ Resid	dence 6	Other (Specify)	
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illied in by the funeral director, page 2	Certification:	27. Manne of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Inju (Month, Da		28b. Time of Injury		Yes 2 □ No	,	d. Describe I				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		4 Homicide determined	building, et	c. (Speci					City or Tox	wn, State)		r Rural Route Num	oer,
	To the Hospitel within 24 hours To the Funerel completely filled	Medical	29a. Certifier 1 Certifying Phy (Check only one) 1 Medicel Exemi	sician: To the best ner: On the basis of and manner sta	f examina	owledge, death o	itigation, in my	opinion, death	place, and occurred	at the time,	date and	place, and	due to the cause(s)
	or Too	2		nna W.			61	596			July	2,	ZOO4	•
			30. Name and address of person who co	W. Ku	IM	0 89	10 Me	clical P	rive	Gart	hers	burg	, MO20.	810
	Sta Registr		31. Date filed (Month, Day, Year)	32. Begistr	ars Signa	ature &	Soak	2						

	1 - For State Registrar	State of Maryland / Dep Ce	partment of Hea		Hygiene	25000
Physician	Decedent's Name (First, Middle, Last)				of Death	3. Time of Death
/Medical	Betty M. I 4a. Facility Name (If not institution, give str		4h Cib. Your calls	74	ly 26, 200	4 06,20AM
Examiner	Union Hospital	eet and number)	4b. City, Town, or Lo Elkton	cation of Death	4c. County of D	eath
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If	Under 24 Hrs. 8. Date Hours Min. (Mont		Birthplace (State or Foreign Country)
Director	214-12-0655	4 2⊠F 82 Yrs.	World Days	NOV	26, 1921 M	laryland
/land	10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
Many Many Mary Many Many Many Many Many Many Many Man	Maryland Cecil	Elkton				1 ☐ Yes 2 ☑ No
vith the Ma or 28a-fe	10e. Street and Number		10f. Zip Code		10g. Citizen of What	Country?
e 23e			21921	ania Oriaina (Canada Va	United	
1036 Durs after death with the Marylan ref, or iteme 23e or 28a-f ehow Examiter must be incitified at 1 by Funeral Director	11. Maritat Status 1 Never Married 2 Married	Armed Forces? 1 □ Yes 2 ☒ No		anic Origin? (Specify Yes Mexican, Puerto Rican, et	c.) Black, W	merican Indian, hite, etc.
C 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Sther than "naturel", or iteme 23e or 28s-1 ehow ent, tra Mexical Examinar must be inclified at e Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No S	Specify:	Specify:	White
21215-005; ed within 72 hours ygiene, ner then *naturel; t, the Medical Ess Completed by	15. Decedent's Educa (Specify only highest grade	completed) (Giv	edent's Usual Occupation ve kind of work done duri	on ing most of working	16b. Kind of Busine	ss/Industry
withir than the comp	Elementary/Secondary (0-12)	College (1-4or 5+)	ashier		A & P Gro	cery Store
be filed tal Hyg d other event,				3. Mother's Name (First, N		ccry blore
arylan should be nd Mental marked c	William E. Conway			Erline C. M	arcus	
and and	19a. Informant's Name/Relationship (Type				Number, City or Town, State	
Pa an in	Betty M. Moore/Sel	20h Place of Dis	position (Name of	Date	kton, Marylar 20c. Location - City	
Pages nent of int: If it	1 ☑ Burial 2 ☐ Cremation 3 ☐ Ref 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Gilpin I Memoria	rematory or other place) Manor	July 28, 2004	Elkton,	
Baltimore, permit. Pages 1 ar Department of Hea Important: if item; eny injury or other once.	21. Signature of Funeral Service Licensee			of Facility For Funerals		Maryrand
0 89889	Donard S.	Heirs	103 W. Stock	kton Street,	Elkton, Mar	vland 21921
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	1950		tory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	Due to for as a construction of	edial Infar	d'ion		Emmeliate
Examiner	Barrier Branch Branch	Due to (or as a consequence of): Conglative Due to (or as a consequence of):	1.00			non the
L S H	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		· Zing cy	7		Years
60, to be executed sicien and burial-transit	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				Years
	d	, , , , , , , , , , , , , , , , , , , ,				
	IF FEMALE:					
P.O. BOX 61 nat the death certific d by the attending p letached for use es:	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of Month	delivery Day Year
. 0 00 -	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4 Pregnant at time of death 5 9 Unknown	5 ☐ Other (s <i>pecify)</i>			33,
		ibuting to death but not resulting in the	underlying cause given i	in Part I. 23e.	Did tobacco use contribute	to the cause of death?
COTCS w require been sig should b					1 X Yes 2□No 3□	Probably 4 Unknown
VITAL RECORDS, sician: The law requires t certificate has been signe rector, page 2 should be BE Completed by				24a.	autopsy prior	autopsy findings available to completion of cause of
				101	performed? death	?
Vita rsician: s certific director,	examiner?	spital:		6. Place of Death (Check		
ig Phys ter this heral dir		28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at		Residence 6 Other (S	респу)
ISION Ittending death. stor: After r the fun	1	(worm, buy rous) Injury		s 2 No		
	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		tion (Street and Number or or Town, State)	Rural Route Number,
Hospitel or 24 hours after 6 Funaral Diraceletely filled in Edical Certification		cian: To the best of my knowledge, de	ath occurred at the time,	date and place, and due t	to the cause(s) and manner	as stated.
o the Hosp ithin 24 hou o the Funa impletely fi	(Uneck only 2 Medical Examine one)	r: On the basis of examination and/or and manner stated.	investigation, in my opina	on, death occurred at the	time, date and place, and o	due to the cause(s)
To the To the Complete	29b. Signature and title of certifier		29c. License ni	umber	29d. Date signed (Mo	onth, Day, Year)
7	" you serve	MP	1115	5 14	July 26	,2004
	30. Name and address of person who com	ipleted cause of death (Item 23a) (Typ	44	Elkton	Mn 2/6	. 7
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	107/1101)	7,7007	/ / - /	
Registrar	AUG 0 9 2004	Selwar &	sports			

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 04 therin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** airhaven If Under Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 18, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2 MARYLAND 213-05-3841 88 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or Items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 154 EAST GREEN STREET APT. 7 21157 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) ASSEMBLY LINE MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FOSTER LONG NUSBAUM EMMA JANE ERB 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If item 27 is any injury or other treu 201 ST. MARK WAY, WESTMINSTER, MD ETHEL M. BELL/SISTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemelery, crematory of other place BENJAMIN'S (KRIDERS) 8/2/04 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) WESTMINSTER, MD LUTHERAN CEMETERY 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 91 WILLIS ST. MYERS-DURBORAW FUNERAL HOME ustr P.A.WESTMINSTER, 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 DN3 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 si autopsy performe 1 Yes 25 1 Tyes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 1 Yes 2 No 3□ DOA 2 ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours e To the Funerel C completely filled proceptifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1Cm 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - For State Registrer		arylan		artment of F			Reg. No.)04	2508	3.2
н	Physici	an	Decedent's Name (First, Middle		51				2. Date of D Month	eath Day	Yea	3. Time of	
	/Medic	al	David	Lee	Pr	nillips	4h Ciby Town o	r I costing of Doo	JULY		2004 County of De	1450	М
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, o		ın				
	Funeral		MEMORIAL HOSPI 5. Social Security Number		e (In yrs. I	ast birthday)	CUMBERLA If Under 1 Year	If Under 24 Hrs	s. 8. Date of B		LEGAN 9. E		or Foreign
	Funeral Director		220-32-3979	1 ⋈ M 2□ F	70	Yrs.	Months Days	Hours Min	8. Date of B (Month, D Jun 9	ay, Year) . 1934	4	Birthplace (State of Country)	
	<u>و</u>		Usual Residence of Decedent							1			
	anylar	_	MD 10b. County	gany	10c. City	, Town or Lo						10d. Inside Ci 1 ☑ Yes	•
	he M	ecto	10e, Street and Number							40- Chi-	en of What		
	with a or	Ö	29 Park Avenue	2			10f. Zip Code	21502		Tog. Citize	USA	Country	
	2 hours after death with the Maryland atural; or litems 23a or 28a-f ahow cal Enaridi et maat ke notified at	by Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba		Specify Yes or N	0- 14		merican Indian,	
တ	r Iter	필	1 Never Married 2 Marr	ied 1 Tyes 2 T					rto Rican, etc.)		Black, W	hite, etc.	
03	ral', c	d by	3 Widowed 4 Divorced	Year or Dates:			1□Yes 2MNo	Specify:			Specify: W	hite	
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121	within ne.	d m	Elementary/Secondary (0-12)	College (1-4or	5+)		school su			Allog	iany C	ount.	
d 2	be filed value Hygie od other favorit, III		17. Father's Name (First, Middle,	Last)		CICIII.	SCHOOL SU		me (First, Middle		jany C	ounty	
an	a da da	To Be	Perry L. Philli	ps					G. Dign				
Maryland 21215-0036	sho ma uma	-	19a, Informant's Name/Relations				ng Address (Street	and Number or F	lural Route Numi	ber, City or	Town, State		
	1 and 2 Health a em 27 le ther tra		Jean Phillips	wife			Park Aven		LaVa	ale		MD 2150	12
ore	t ite		20a. Method of Disposition 1 Surial 2 Cremation	3 □Removal from State			sition (Name of natory or other place		Date		ation - City	or Town, State	
Ë	mit. Pages partment of l portant: If its injury or o		'4 □ Donation 5 □ Other (S		Res		emorial Gai		7/31/2004	LaV	'ale	IV	1D
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service	Licensee	\sim) ~ 2	Name and Addre Scarpel	ss of Facility Ii Funeral H	Home, PA				
	403 6 0		23a. Part1. Enter the disease, or	complications that cause	The death	Do not on		ginia Avenu			MD 215	502 Approximat	10
	20		shock, or heart failure. List Immediate Cause (Final	only one cause on each li	ne.					arrest,		Interval Bet Onset and (ween Death
	Pnysician /Medical		disease or condition resulting in death)	a. HEMORRH.			AL VASCU	LAR ACCI	DENT			2 WEER	ζS
	Examiner				a consequ	derice or).							
×	MESSES.	Jer	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Oue to (or as	а сопвади	ience of):							Name of the last
	xecuted and Il-transit	Examine	that initiated events	c									
0,	be exe sician a burial-		resulting in death) Last	Due to (or as	a consequ	uence of):							
8760,	eti 98	Physician/Medical		d									
9 X	n certifica anding ph use as th	/Me	IF FEMALE:	23c. If yes, outcome	of oregna	ncv				0.0	ad Data of	deline	
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3[Ectopic pregnancy Other (specify)	1		23	3d. Date of o Month	•	Year
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٣.	law requires that the as been signed by the 2 should be detached	by P	Part II. Dther significant condition					en in Part I.	23e. Did	tobacco us	e contribute	to the cause of d	eath?
Vital Records,	w require been sig should b		DIABETES MELLIT	TUS WITH DIA	BETIC	NEPHE	ROPATHY		1 🗆	Yes 2	No 3□	Probably 4 □t	Jnknown
ecc	law reas be	Completed				_			24a. Wa	s an opsy	24b. Were	autopsy findings	available
<u>=</u>	ian: The l	Com							perl 1 ☐ Yes	ormed? 2 D No	death	?	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hamital			045		ath (Check only				
of	Phys this ral dir	2	1 ☐ Yes 2 12 No 27. Manner of Death	1 Inpatie	1	ER/Outpatier 28b. Time o		4 🗀 Nursing	Home 5 Res			pecify)	
		tion	1 ☑Natural 5 ☐ Pendin	g (Month, Da	y Year)	Injury	Wor	k? Yes 2 □ No	200. Describe	now injury	occurred		
Division	r Attending er death. rector: After by the fune	fica	3 Suicide 6 Could	not be 28e. Place of In			eet, factory, office				Number or	Rural Route Num.	ber,
Ο̈́	al or Att	Certification:	4 Homicide	building, et						wn, State)			
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b		29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the best	of my know	wiedge, deat	occurred at the tir	ne, date and plac	e, and due to the	cause(s) a	ind manner	as stated.	
	the H iin 24 the Fu	ledical	one)	Examiner: On the basis of and manner st	ated.	ion and/or in			urred at the time)
	To T To I	Σ	29b. Signature and file of certifie	Viole -			29c. Licens	e number		29d. Date	signed (Mo	nth, Day, Year)	
•			- Jun	2 weldom	1		D160	041		JULY	29,	2004	
	10		30. Name and address of pasch					OT ANTO MAA	DVT ANT	21500			
	Sta	to.	DR. TERRY WILLIA 31. Date filed (Month, Day, Year)	MS 500 MEMO			E COMBE	RLAND, MA	LILAND	21502	yyy Iy	W-24K-3	-
	Registi			G 0 9 2004	21		Sociale	و ابو					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month & **Physician** MICHAEL JOSEPH, ROACH 04 8:30 AM 01 - /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore 14 Medical Baltimore Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 2/5/48 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1⊠ M 2□ F 212-48-9222 56 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location or 28a-f show other traumatic event, the Medical Examinar must be notified at ¥ Yes 2 No Director Harford Havre de Grace MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 410 Tidewater Drive 21078 U.S.A. or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after c and Mental Hygiene. Is marked other than "natural", or ffer 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ lt Yes, Give Year or Dates: Vietnam 3 ☐ Widowed → Windowed Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked t any Injury or other traumatic ew Mary L. Rolf Bill Roach, Sr. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 Michael Roach, Jr. 1709 D Crimson Tree Way, Edgewood, MD (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdns.8/4/04 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 Signature of Funeral Service Licensee 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 8 YRS KIONET DISTASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to for as a cons y uence of Examiner burial-transit requires that the death certificate be executed that initiated events resulting in death) Last physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year ŏ in the past 12 months? Month Day 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown HUPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2353EAIG page 2 autopsy performed? certificate 1 Yes 2 🗓 or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Empatient 2 ☐ ER/Outpatient 3□ DOA filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending Injury 1 Tyes 2 - No investigation 2 ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13-11382 08-01-04 VAH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Balva & Apostis ? AUG 0 9 2004

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 24,2004 JULY **Physician** 5:19P ANTOINETTE CECELIA SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES LA PLATA CIVISTA MEDICAL CENTER 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2√□ F 79 Yrs. NOV.9,1924 PA. 200-12-2695 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f ahow the Medical Examiner must be nutitled at 1 ☐ Yes 2 ☑ No Funeral Director MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20602 U.S.A. 2082 CHAPELSIDE COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " DEPT.OF AGRICULTURE Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 12 U.S.GOVT other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F should be JOSEPH MICHAEL COLIN CECELIA ELIZABETH LAFFERTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM E.SMITH-SPOUSE 2082 CHAPELSIDE CT. WALDORF, MARYLAND 20602 f Health 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 20a Method of Disposition 0 Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If 0 METROPOLITAN CREMATORY 7-27-04 ALEXANDRIA, VIRGINIA 2. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Juneral Service Licenses MO0479 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that lawed shock, or heart failure. List only one cause for each lin ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** W50 resulting in death) /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of) Due to (or as Examiner ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of Physician/Medical attending for use as 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 Other (specify) Yes ed by the a P.O. 9 Unknown 9 Unknow been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 has certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. i Diractor: A investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide after within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0629 nd address of pe son who completed cause of death (Item 23a) (Type, Print) .WATHEN, MD 11345 PEMBROOKE SQ. WALDORF, MD. 20602 GEORGE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

		3	For State Registrar	State of M	larylan		artmen rtificate			and M		Reg. No	$2 \mathrm{n}$	04	251	185
	Physicia	an	Decedent's Name (First, Middle, Last)	Leah	Kathr	yn Sh	noll				2. Date of D Month July	Death Da 26	ay	Year 2004	3. Time 4:15	of Death
	/Medic Examin	_	4a. Facility Name (If not institution, give 61 George Street)			Town, or neyto	Location o	of Death		40		ty of Deeth	Count	У
	Funeral Director		213-24-0243	7. A	ge (In yrs.	last birthday) 76 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I Apr.	Jav. Year	928	9. Birthp Cour Mary	itry)	or Foreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll	County	1	y, Town or Lo aneytow						7		1	0d. Inside	City Limits
	with the a or 286 be not	Direc	10e. Street and Number 61 George Street				10f. Zip		787					What Cour State		
980	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "naturel", or items 23a or 28e-f show of other than "naturel", or items 23a or 28e-f show event, the Medical Examinar motal be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. Was Deceden Armed Forces 1 □ Yes 2 ¼ If Yes, Give Year or Dates	?]No		Was Deced If Yes, spec	dent of Hi			ecify Yes or I Rican, etc.)		14. Ra BI	ace - Americ ack, White, ify: Whi	etc.	
21215-0036	vithin 72 ne. han "na e Madic	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11	cation e completed) College (1-4or	5+)	(Give	dent's Usua kind of wo DO NOT us emake	rk done d se retired	ation during mos)	t of work	ing			Business/In	dustry	
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Mar	C/ 40 mm m		19a. Informant's Name/Relationship (7) Pamela S. Harlow		ter		ng Address Tyro				al Route Nun stmins					8
lore,	00-		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F		20b. F	Place of Disponentery, creatinity	osition (Nar matory or o	ne of ther plac			29 2004	20c. l	ocation	- City or To	own, State	
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8	80 E 2 9		Alan C. Yur 23a. Part1. Enter the disease, or comp	ications that cause	ed the deat						Street or respiratory		neyt	cown,	MD 21 Approxim	ate
2.0	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or a	0	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	2 ~	(94	(e)					Snset an	
	Examiner	er	if any, leading to immediate	b. — Due to (or a						·)
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.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta at time of c	al death 3	⊒Ectopic p ⊒ Other (s¢							Date of delive	ery Day	Year
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Division of	ling After fune	Certification:	27. Manner of Death 1	28a. Date of In (Month, E	Day Year)	28b. Time of Injury	М		yat k? Yes 2 □	No	28d. Describ				-/ D N	
Divi	E 5 # 6		4 Homicide determined		etc. (Speci	ify)						Tòwn, Sta	ite)			umber,
	ne Hospital n 24 hours a ne Funeral C	Medical	29a. Certifier 1 X Certifying Phy (Check only 2 Madical Exem	inar: On the basis and manner	of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tir n, in my o	ne, date ai pinion, dea	nd place, ath occur	red at the tim	ne cause ne, date a	nd place	e, and due t	o the cause	B(s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	30			29		e number	64	61	29d. D	ate sign	ned (Month.	Day, Year	·)
	5		30. Name and address of person who				_				A. 173	25	1	-010	_,_	
	St. Regist	ate rar	SATISH SHAH, M. 31. Date filed (Month, Day, Year)		rAIRF strag's Sign		Ш. ,		1 -	-, -,						

		-	- State Amend Item 23	State of Maryland / E Ba per Dr., G834.0	Department of H	ealth and M	lental Hyg	iene	25086
			Hegistrar		Gennearo or L	Jealii	2. Date of Deat	eg. NoC U U ≒∳	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, Last) Anna Catherine St	ronor			Month	Day Year	
	/Medic	_			0. Ch. T	Leasting of Dooth	July	19, 2004 4c. County of Deat	10:30 A M
	Examin	er	4a. Facility Name (If not institution, give s			Location of Death		Allegany	
30	5 ×		12911 St.Patrick's		Little 0	If Under 24 Hrs.	8 Date of Birth		hplace (State or Foreign
	Funeral Director		217-09-3003	7. Age (in yis. last bit	Months Dave	Hours Min.	8. Date of Birth (Month, Day, February	1,1919	MD
	p .	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	m or Location				10d. Inside City Limits
	aryla sho	2							1 □ Yes 2√⊡ No
	Me M	Director	MD Allegany 10e, Street and Number	Little	Orleans 10f. Zip Code		1	0g. Citizen of What Co	untry?
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	s 23	Funeral	12911 St.Patrick's	S KD, S.E. 12. Was Decedent Ever in U.S.	2176		ecity Yes or No-	14. Race - Ame	rican Indian,
	er de item nerr	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	13. Was Decedent of H If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
9	rs aft	by F	3 ☑ Widowed 4 □ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify: Wh	ite
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ā	should be filed within the Mental Hygiene. Imarked other then matic event, the Mental Hygiene.	To E	John William Stac	hnick		Katherin	ne Anna	Eigner	
Maryland 21215-0036	o,		19a. Informant's Name/Relationship (Ty	pe, Print) 19t	b. Mailing Address (Street	and Number or Run	al Route Number	r, City or Town, State, 2	Zip Code)
	alth a	1 3	Richard L.Stoner, J	r/Son 1	.2905 St.Patr				
Baltimore,	of He fitem	1 3	20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ F	comoto	of Disposition (Name of ery, crematory or other place		Date	20c. Location - City or	Town, State
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a	permit. Pag Department Important: I any injury o		21. Signature Funeral Servi - Licens	2 10	22. Name and Addre	ss of Facility		141 West M	ain Street
m	88 5 8		Thul	S/ areve	Grove Fune	eral Home	P.A.	Hancock,MD	21750-0368
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	cations that caused the death. Do ne cause on each line.	not enter the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as a consequence					
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760,	te be executed ysicien and e burial-transit	ũ	resulting in death) cast	Due to (or as a consequence	3 OI).				
876	icate b physic s the b	dical		d					
89 x	eath certificate attending phy I for use as the	Physician/Medi	IF FEMALE:	23c. If yes, outcome of pregnancy				02d Date of de	lineare
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-	the a	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	5 Citier (specify)				
P.O	The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the	P.	Part II. Other significant conditions co	intributing to death but not resulting	in the underlying cause giv	ven in Part I.	23e. Did to	bacco use contribute to	of the cause of death?
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3ec	The law cate has l	E E	\				autop perfor	med? prior to death?	completion of cause of
a						00 Pt	1 Yes		s 2 No
Ζ	Physician: this certificant	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpotiont 207 DOA Ott	26. Place of Dea		dence 6 □Other (Spe	noife)
of Vital Records,		5	1 Yes 2 No 27 Manner Peath	28a. Date of Injury 28b.	. Time of 28c. Inju	ry at		now injury occurred	schy
O	ding h. Afte fune	ţ	1 Shatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury Wo	rk?]Yes 2∐No			
Division	l or Attending after death. Director: Afte in by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home.	farm, street, factory, office			Street and Number or F	lural Route Number,
Ö	after after Dire	ert	4 Homicide	building, etc. (Specify)			City or Tow	m, State)	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	(Check only 2 Medical Exam	vsician: To the best of my knowledginer: On the basis of examination a	ge, death occurred at the ti and/or investigation, in my	ime, date and place opinion, death occu	, and due to the cred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 24	Med	29b. Signature and title of certifier	and manner stated.	, 29c. Licen	se number		29d. Date signed (Mon	th, Day, Year)
	To vil			IN PHYSICE)5084	4	07/10	1/04
			/ //	//		0 0 /			
	5		30. Name and address of person who can be a second address of person address of	- 010	Seton Dr.	Cumper	land	MD 21502	
	St	ate	Jose T. Lover 31. Date filed (Month, Day Year)	32. Registrar's Signature		Cumilei	uiid	110 21002	
1	Regist		AUG 0 9 2004	Densie	Sports				

			1 - For State Registrar	State of Mary			of Health of Death		Hygien Reg. N	other the second	25007
			Sonja Elaine Tim					2. Date of Month	D	19 20	3. Time of Death
						4b. City, To	wn, or Location	of Death		c. County of De	
1 - State Registrar					yrs. last birthday	Hager		r 24 Hrs. 8. Date of		Washing	
	Director		213-40-4269	М 2∏Г	63 Yrs.		Days Hours		, Day, Yea.	r)	irthplace (State or Foreign Country) MD
	h with the Maryland 3a or 28e-f ehow st be notified at	ai Director	MD Washingto 10e. Street and Number	n	c. City, Town or I Hagerst					itizen of What	10d. Inside City Limits 1 X Yes 2 □ No Country?
920	ours after deat rai', or itams ? Eracilier ou	by	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		. Was Deceder If Yes, specify 1 ☐ Yes 21		rigin? (Specify Yes o in, Puerto Rican, etc.	No-	Black, W.	merican Indian, hite, etc. White .
21215-0	f within 72 ho liene. r than "natui ir e Modical	ompieted	(Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Giv life.	edent's Usual C e kind of work DO NOT use	done durina mo	st of working		Kind of Busines	,
land	ild be filed lental Hyg ked othe ic event,	Be	17. Father's Name (First, Middle, Last)			W213116-1		er's Name (First, Mic trude Pie:	ddle, Maide		
Mary	nd 2 shou Ith and M 27 ie mar r treumat		19a. Informant's Name/Relationship (Type				Street and Numb	er or Rural Route Nu	ımber, City		gs, WV 25411
nore,	ages 1 au ant of Hea tt: If itam y or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	Ob. Place of Disc	osition (Name ematory or othe	of er place)	Date 07/21/04	20c. I	Pool, I	or Town, State
Baltir	permit. P Deportme Importan any njur				1	22. Name and A	Address of Facil		41 We	st Main	Street
			shock, or heart failure. List only or Immediate Cause (Final disease or condition	eations that caused the e cause on each line.						CI(,111) 2	Approximate Interval Between Onset and Death
X 692	be executed cian and purial-transit		Sequentially list conditions, any loading interesting cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	onsequence of):	lane					Idoup
O. Box 6	the death certific y the attending pi ched for use as i	nysician/Medi	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregi □ Other (s <i>peci</i>			-	23d. Date of d Month	lelivery Day Year
Ś	res tha igned be de	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the	underlying caus	se given in Part		id tobacco	_	to the cause of death? Probably 4 Dunknown
al Reco	The law ate has b page 2 si	Comple							utopsy erformed?	prior to death	
Vita	ilcien certifi rector	0	examiner?	ospital:			Other	e of Death (Check or			
on of	ding h. After fune	H=	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Ye	2 ER/Outpation 28b. Time Par) Injury		Injury at Work?			6 □Other (Sp ury occurred	pecify)
Divis	ai or Atter s after dea if Director of in by the	Sertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - building, etc. (S	At home, farm, s Specify)	treet, factory, o	ffice		n (Street a Town, Stai		Rural Route Number,
	he Hospit n 24 hours he Funere		(Check only 2 Medical Examir	sician: To the best of mails. To the basis of examiner: On the basis of examiner stated.	y knowledge, dea amination and/or i	th occurred at to	the time, date as my opinion, dea	nd place, and due to ath occurred at the tir	the cause(s	s) and manner ad place, and d	as stated. ue to the cause(s)
	To the within To the Comp		Δ. 17				icense number			ate signed (Mo	
)			· Wy			D	2836.	5		7.19.09	7
	3		30. Name and address of pe n who co	mpleted cause of death 8 MUS & 32. Registrates	(Item 23a) (Type tved-14	. Print) eigester	nu to	021790			-
1	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9	32. Registras s	Signature	- Brose	S. Y.				

Physic	ian	1. Decedent's Name (First, Middle,	Last) Ana Mar	ia Chavez-	Vitervo		2. Date of De	ath Day	Year	3. Time of Deat
/Medi				RVO-			July	16,	2004	09:50 A
Exami	ner	4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
		Harford Memoria 5. Social Security Number 6		(In yrs. last birthday		de Grace If Under 24 Hrs.			ford	
Funeral Director		220-67-3229	1 M 2 F	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	iy, Year)		lace (State or For
		Usual Residence of Decedent			8		Nov. 9	, 2003	Mary	Land
show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Li
Ba-f	cto	Maryland Somerse	t	Princes	s Anne					1. Yes 2
23a or 28a-f should be notified at	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	itry?
ms 23a or 28a-f show	rai	30397 Mt. Verno			21853			UŞA		
Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Itams 23a any injury or other traumatic event, tre Medical Evantral rulal 100ce.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	lo 13.	Was Decedent of His If Yes, specify Cuban 1 ☑ Yes 2 ☐ No	Specify:		Spe	lace - Americ lack, White, cify:	etc.
e dia	edi	15. Decedent's		16a Dece	dent's Usual Occupat		ican	16h Kind of	H1S Business/Inc	panic
, c	Completed	(Specify only highest (Secondary (0-12)	grade completed) College (1-4or 5-	(Give	kind of work done du DO NOT use retired)	uring most of works	ing	100. Kiria oi	Doginess/inc	austry
giene er the	E O	0	none	No	ne			Nor	ne	
d oth	Be (17. Father's Name (First, Middle, La	·			18. Mother's Name			,	
Men	2	Celerino Chave					na Vite			
n 27 is n		19a. Informant's Name/Relationship Cenorina Viterv		ther 3039	ng Address (Street ar 7 Mt. Veri	non Rd.,	Prince:	er, City or Tom SS Anne	m, State, Zip	^{Code)} 21853
of He if itan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of matory or other place,) .	ate	20c. Location	n - City or To	wn, State
tant: lury o		' 4 ☐ Donation 5 ☐ Other (Spec	cify)	Salisbur	y Cremator	y 07/1	9/2004	Salisb	ury, N	faryland
Depar Impor any in		21. Signature of Funeral Service Lic	0	22	2. Name and Address	of Facility Hin	man Fur	neral H	lome	
	Н	23a. Parti. Enter the disease, or co			1673 Somer				e, Md.	21853
hysician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease ur injury that initiated events resulting in death) Last	c	consequence of):						
shys the	ledical		d							
ad by the attending p detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	y Day Year
been signed should be del	d by P	Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause given	in Part I.	23e. Did to	-		a cause of death
s has been ge 2 shoul	Completed						24a. Was a autop perfor	sy	prior to com death?	sy findings avail pletion of cause
pa	Be	25. Was case referred to medical examiner?				26. Place of Death				
ertificate ha ector, page	2	1 Yes 2 No	Hospital:	11	The second second second	4 Nursing Hon	ne 5 🗆 Resid	ence 6 🗆 O	ther (Specify)	
this certificate at director, pag		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati		Year) 28b. Time of Injury	28c. Injury a Work? M 1 \(\sum Ye	it 2 os 2 □ No	8d. Describe h	ow injury occu	irred	
eath. :or: After this certificate the funeral director, pa				v - At home farm str	eet, factory, office	2	8f. Location (S City or Tow	treet and Nun n, State)	ber or Rurai	Route Number,
n. After this certific funeral director.		2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injur building, etc.	(Specify)				,		
n 24 hours efter death. 1e Funerel Director: After this certificate bletely filled in by the funeral director, pa	Certification:	3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	d 286. Place of injur	my knowledge, death	occurred at the time, estigation, in my opin	date and place, a	nd due to the co	ause(s) and mate and place	nanner as sta , and due to	ted. the cause(s)
within 24 hours efter death. To the Funerel Director: After this certificate completely filled in by the funeral director, pa		3 Suicide 4 Homicide 6 Could not determine 29a. Certifler (Check only 2 Medical Ext	building, etc. Physician: To the best of aminar: On the basis of e	my knowledge, death	29c. License r	nion, death occurre	d at the time, o	late and place	, and due to	ay, Year)

			For State	State of Mar	yland / Depa		lealth and	Mental Hygi		n I	25000
				t)				2. Date of Death		1111	3. Time of Death
	Physicia	an						Month	Day	Yeer	
*						1		August	4c. County	2004	11:50 P. ^M
Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Charles E. Adkins, III 4a. Facility Name (If not institution, give street and number) 1750 Little Creek Drive 1750 Little Creek Drive 5. Social Security Number 6. Sex 219–28–1607 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Baltimore 10b. Street and Number 10b. Street and Number 1750 Little Creek Drive 11. Marital Status 10b. County 10c. City, Town MD Baltimore 10c. Street and Number 11b. Marital Status 10b. Street and Number 11b. Marital Status 11b. Marital S						46. City, Town, o	or Location of Deat	n			
							dlawn		Ba.	ltimo	
-	Funeral					If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Yeer)	9. Birthpi Coun	lace (Stete or Foreign try)
	Director		219-28-1607	7	2 Yrs.			June 4	1932	MD	
	2 .	}		1	Oc City Town or L	ocation				1	Od. Inside City Limits
	hoy		Toa. State		oc. City, Town of E	ocation					1 ☐ Yes 2 M No
	19-1-19	5	MD Baltim	ore	Wo	ood1awn					
	or 28	ire	10e. Street and Number			10f. Zip Code		10	g. Citizen of \	What Coun	try?
	88	- B	1750 Little Creek	Drive			21207	1	USA		
	ma Cean	Jer		12, Was Decedent Ev	er in U.S. 13.	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)		e - Americ	
0	i i	Ē	1 Never Married 2 Married	1 Yes 2 No				to rican, etc.)			BIG.
က္က	Er C	by	3 Widowed 4 Divorced	Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify	/ :	White
Ģ	atur	ted			16a. Dece	edent's Usual Occup kind of work done	pation	dia a	6b. Kind of B	usiness/Ind	lustry
7	u u	pie			life.	DO NOT use retire	ed)	rking			
2	iene iene	Eo				nputer Pr	ogrammer	Sc	ocial S	Secur	ity Adm.
0	a the	a	17. Father's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·		18. Mother's Na	me (First, Middle, M	aiden Suman	ne)	
au	0 0 0 0 0	00	Charles E Adkins	Tr			Frnest	ine Breve	r		
<u> </u>	nari mati	F			19b. Mail	ing Address (Street		ural Route Number		State, Zip	Code)
Z Z	h an h an 7 ie trau										
	Heali Heali Her		·····	tii/Sister	20b. Place of Disp	Northway	DIIVE	Havre de	Oc. Location		
	m O L			Removal from State	cemetery, cre	matory or other pla			oo. Eboution	only or re	, 5.0.0
Ē	ent:				Balto-Was	sh Cremat	ory 08/	06/2004 1	Laure1	, MD	
<u>#</u>	port port y inj		21. Signature of Funeral Service Licen	SOO	2	2. Name and Addre	Ashton S	chwab Fune	eral Ho	ome.	Inc.
m	89 = 5 9		Jates S.	tual		736 Edmon	dson Ave	. Baltimo	re, MD	2122	8
1			23a. Part1. Enter the disease, or comp	olications that caused the	ne death. Do not en	iter the mode of dy	ing, such as cardia	c or respiratory arre	st,		Approximate Interval Between
	Navalaiaa		Immediate Cause (Final			00.01	00				Onset and Death
	hysician /Medical		disease or condition resulting in death)	u	Consequence of).	nuejean	cancer			-	5 Months
35	Examiner			Due to (01 as a	consequence or).	(50)					
		<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
	isit ed	in	Cause (Disease or injury							1	
	le be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c	consequence of):						
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876	ate t hysic the t	lical		d							
68	ng p	Mec	IF FEMALE:				17.13				
Вох	leath certificate attending phys I for use as the	Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		□Ectopic pregnanc	ev		1	te of delive	
	deal e att	ich	in the past 12 months? 1 Yes 2 No	4☐Pregnant at ti		Other (specify)	,		MIC	onth	Day Year
0	by the a	hys	9 Unknown	9□ Unknown							·
٥	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause g	ven in Part I.	23e. Did tob	acco use con	tribute to th	ne cause of death?
ds	urae Sign	d by						1 🗆 Yes	s 2 🗆 No	3 Prob	ably 4 Unknown
of Vital Records,	v require been si should I	Completed						24a. Was an	24b	Ware auto	psy findings available
še	has has	npi						autopsy	,	prior to co	mpletion of cause of
		S						1 ☐ Yes 2	No	1 ☐ Yes	2 No
ita	ysician: Th	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one)		
2	d is	10	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA	her: 4 🗆 Nursing	Home 5 Resider	nce 6 Oth	ner (Specif	y)
			27. Manner of Death	28a. Date of Injury (Month, Day	Yeer) 28b. Time	of 28c. Inju	iry at	28d. Describe hor	w injury occur	red	
Ö	nding I Ith. :: After e funer	atio	1 Natural 5 Pending 2 Accident investigation		, co.,		Yes 2 □ No				
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	286. Place of injur	y - At home, farm, s	treet, factory, office		28f. Location (Str		ber or Rura	I Route Number,
á	after Dire	erti	4 Homicide	building, etc.	(Specify)			City or Town,	State)		
	spita ours ieral filled		29a. Certifier 1 ★ Certifying Ph	vsician: To the best of	my knowledge dea	ith occurred at the t	ime, date and niac	e, and due to the ca	use(s) and m	anner as s	tated.
	Fun Fun tely	edical	(Check only 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	nvestigation, in my	opinion, death occ	curred at the time, da	te and place,	and due to	the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and maillet 2(2(6	JG.	29c Licen	ise number	29	d. Date signe	d (Month	Dey, Year)
	5 4 K		A A A		10 -1 1	* /	0372	1			
	1		Christine -	Ham, 1	ND, Phi	7 10	00312		ingus	T 5,	2004
	- 1	1	30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	Print)					
	10							2-7.			
	Y		600 N. Wolfe		altimore		2128	37			

State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND ITEM #17 PER FH C834 8/31/04 JH 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street City, Town, or Location of Death County of Death Examiner Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Age (In yrs. last birthday **Funeral** Days 220-36-8485 Director 64 May 28, 1940 NY Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. In side City Limits 10a. State 23a or 28a-f show ortant: If item 27 is marked other than "natural", or itams 23a or 28a-f shov injury or other traumatic event, the Medical Exami ser must be notified at 1 ☐ Yes 2 ▼ No Be Completed by Funeral Director Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 119 Benfield Road 21146 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Self Employed Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be ၉ Jurgen Albright FRNEST JURGEN ALBRIGHT Thelma Mae Filatrault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mrs. Carol Albright / wife 119 Benfield Road, Severna Park, MD 21146 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or Gardens of Faith Aug 7, 2004 Baltimore, MD 21. Signature of Puneral Service Licenses 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUDDEN /Medical Due to (or as a consequence of): **Examiner** ARDISMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Certification; To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-tranet that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 X ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAKWOOD ROAD GEEN BURNIE J882 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 0 2004 DHMH 17 Rev 1/2001

	. For		State of Ma	aryland / D	epartment of	Health and I	Mental Hyg	jiene		
	1 - State Regist			(Certificate o	f Death	R	eg. No.	11	25191
Physician		Name (First, Middle,	1	1	111 00)	2. Date of Dea Month	Day	Year	3. Time of Death
/Medical	1 7 10	DOIDRE	give street and number)	aA	ITH OTT.	, or Location of Death		8, 200 4c. County		3:23 am ^M
Examiner			re Medical	Center	Towson		'	Balti		
Funeral			3. Sex 7. Ag	e (In yrs last birth		ar If Under 24 Hrs.	8. Date of Birth (Month, Day	1		place (State or Foreign
Director		14-0831	1□M 2 1 F	80 v	rs.	Tiours Willi,	3-26	2//	OAL	-to.NP
and	10a. State	lence of Decedent 10b. County		10c. City, Town	or Location				1	10d. Inside City Limits
Mary Pa-f sh	mi	BAL	TIMORE	B	ALTIM	ORE				1 ☐ Yes 2 No
ith the	10e. Street	and Number	1 - 0:	01	10f. Zip Code	9	1	l0g. Citizen of V	Vhat Cour	ntry?
6 Safet deeth with the Maryland or teme 23s or 28s-1 show other must be notified at	24	75 WOC	2-2-	Ka.		२१२३५.		U	5H	
figure de la company de la com	11. Marital S	Status er Married 2□ Marrie	12. Was Decedent Armed Forces? d 1 Tyes 2 X		1.7	of Hispanic Origin? (S uban, Mexican, Puert	o Rican, etc.)		k, White,	etc.
0036 0036 Fall., o	3 Wic	lowed 4 Divorced	d 1 ☐ Yes 2 🐧 If Yes, Give Year or Dates:		1 □ Yes 2 N	lo Specify:		Specify	W	rite.
21215-00 ed within 72 ho ygiene. 'natura	2	15. Decedent's (Specify only highest		(Decedent's Usual Occ Give kind of work don	ne during most of wor	king	16b. Kind of Bu	siness/Ind	dustry
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Ind 2 Ind 2 be filed tal Hygi d other		Name (First, Middle, Li	ast)	762	201. 110		ne (First, Middle,			11031,
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Maryland A 2 should be file th and Mental Hy 77 is marked oth treumatic even		ant's Name/Relationshi	p (Type, Print)	19b. I	Mailing Address (Stre	et and Number or Ru	ral Route Number	, City or Town,		
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altimor altimor mil. Pages partment of the yielury or or		re of Funeral Service Li		Toly N	22. Name and Add	em. 8 1	ALTI MO	RE.M.	DZ	1234
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	23a. Part1. shock	Enter the disease, or o , or heart failure. List o	omplications that caused nly one cause on each it	the death. Do no	ot enter the mode of d	lying, such as cardiad	or respiratory arr	est,		Approximate Interval Between Onset and Death
Physician (Madical	Immediate disease or resulting in			-spinate		re			_ 16	Onset and Death
/Medical Examiner			4.0	a o nsequence of		1.				
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58760 icate be e physician s the buri			d							
Box 6 sath certifi attending for use as	IF FEMALE	ecedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date	e of delive	∍ry
. B. death	in the	past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			Mor	nth	Day Year
Records, P.O. Box 6 The law requires that the death certifi te has been signed by the attending sage 2 should be detached for use as	9 0	nknowń	s contributing to death b		Nha wadan dan sawa	mineria Danii	220 Dida		dhuan an ab	ha assume of de-sh2
cords, P.(v requires that the been signed by should be detected by Physical Control of the beautiful to the	5	ir significant condition	is contributing to death of	at not resulting in	the underlying cause (given in Part i.	230. Did to	\ /		he cause of death?
of Vital Records, Physicien: The law requires to this certificate has been signeral director, page 2 should be or	<u> </u>						24a. Was a		Vere auto	psy findings available
Vital Rec							autops perfor	med2 p	rior to cor leath?	mpletion of cause of
		se referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		Yes	2/2No
hysic ce all direct	1 Ye	2 No	Hospital: 1 npatie		Jalient 3 DOA		ome 5 Resid			y)
Division of the or Attending P is after death. el Director: After I ed in by the funers	27. Manner	ural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28b. Tir Inj	ury W	ijury at vork? □ Yes 2 □ No	28d. Describe h	ow injury occurr	ĕd	
Division 1 or Attending after death. I bip the fune	2 Ac	cide 6 Could no	t bo	ury - At home, farr	n, street, factory, offic		28f. Location (S	treet and Numb	er or Rura	ıl Route Number,
Div Div safter sel Dive ed in t	4 □ Ho	miciae	building, et	c. (Specify)			City or Town	n, State)		
the Hospi in 24 hour the Funer pletely Mi		er 1 Certifying	Physician: To the best xaminer: On the basis o	of my knowledge, f examination and	death occurred at the	time, date and place	, and due to the c	ause(s) and ma ate and place, a	nner as st	lated.
Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely fitled in by the funeral director, and Madical Certification. To Be Completely	one)	ure and title of certifier	and manner st	ated.		ense number		9d. Date signed		
F 2 5 8	- Signal	11	in Minh	MO	3	55301		08/0	8/0	54
\0	30. Name a		completed cause of c		pe, Print)			- 1		Jones In
L _ Y		phth	con 1	Therete	- Dul	inco	eal.	Cente	0	John La W
State	31. Date file	(Month_Day, Year)	32. Registr	ar's Signature	1					/

Registrar

AUG 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Oa PER FH C834 Certificate of Death

Reg. No. State Registre #10a PER FH C834 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Name (If not institution, give street and number) 4a. Facility 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aris imonium TIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Se **Funeral** Birthplace (State or Foreign Country) 213-34-737 Usual Residence of Decedent 1 M 2□F Months Yrs 6 Director with the Maryland 10a. State DE 10b. County 7 is markad othar than "natural", or itams 23a or 28a-f ahow traumetic avant, the Medical Evanting must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director eanvier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9970 death Funeral 4:15 p.m. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ital enty injury or other traumatic event 1 Never Married 2 Married ☐Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) achinis AUGUST 7, 2004 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Be Maiden Sumame, Allen enis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory of other place) BALTIMORE, MD 21236, athleen Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hills Cencetery 18-Middle Kiver, MD 21. Signature of Funeral Service Cicense ALTIMORE, MD 21224. ALCHAPEL, 8800 HARFORD 20 22. Name and Address of 23a. Part1. Enter the diseas shock, or heart failure. of confilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): physician Box 68760 Physician/Medical the for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown þ signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ MAURICE ALLEN 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate? 1 Yes 2 No Division of Vital 1 ☐ Yes 2 X No tha Hospitel or Attanding Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one. examiner Hospital: Other: 1 ☐ Yes 2 😿 No P 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural ~ 2 Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No Diractor: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à determined 4 Homicide within 24 hours a To the Funerel D TX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registra

AUG 1 0 2004

			For State Registrar	State of Mar		artment of F		F	eg. NG. () ()	4 25	093		
	Physici	an	Decedent's Name (First, Middle, Las	-				2. Date of Dea Month	Day	Year	Fime of Death		
	/Medio		4a. Facility Name (If not institution, give	Street and number)	·	4b. City, Town, o	r Location of Dea	AUGUST	4c. County	-00/	5.21		
	Examir	ier	House County	General	fospital	Colv	mbia			MARD			
	Funeral		Social Security Number 6. S		In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir				State or Foreign		
	Director		212-20-0001	ZAM 2LIF	77 Yrs.			MAY 24		Marylar	nd		
	and and		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. In	side City Limits		
	Mary -1 sh	to	Maryland Howard		E11	ridge			1 🗆 Y				
	or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?			
	23a c	Funeral Director	6703 Handley Dr	ive		210	75		US	SA			
	er des tema	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub.	lispanic Origin? (an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)		e - American Ind k, White, etc.	dian,		
36	rs afte	by F	1 ☐ Never Married 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	1 ∆Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify	Whit	e		
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itema 23e or 28e-f show the Madical Excinitur mat be millfied at	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	usiness/Industry			
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21	ygien ygien yerth t, the	Con		4	Ac	countant			Defer				
and	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)	aker Sr				ame <i>(First, Middle,</i> z Emma Sha		16)			
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Ma	and 2 s Baith an n 27 is Ber trau			ean Baker/Son 6703 Handley Drive E							,		
ē,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Place of Dispe		-334-310	Date	20c. Location -		tate		
E	Pages nent of int: if it		1 ☐ Burial 2 XCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			ematory,		/5/04	Balt:	imore,	MD		
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itema 23a or 28a-f show any Injury or other traumatic event, the Mudical Examination at the natified at ance.		21. Signature of Funeral Service Licen	see h:	2	2. Name and Addre	ss of Facility	ety of 1	MD. In	C			
	207 29	// /	Edward A G	egorchik		99 Fred	erick	Road Ba	ltimor	e, MD	21228 oximate		
760,	Praysician and //Medical Examiner	icai Examiner	shock, or heart failure. List only the terminal		consequence of):	FAILURE					val Batween at and Death		
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	as tha gned l	by P	Part II. Other significant conditions of	Α.Φ	-	inderlying cause giv	en in Part I.		bacco use conti		-		
ord	w require been si should b	ted	Acute Renal	Insufficie	ney			- 1 Y	es 2 No	3 Probably	4 Unknown		
al Records,		Completed	Dehydration					24a. Was autop perfor 1 \sum Yes	med?	Were autopsy fir prior to completi death? I Yes 2 1	on of cause of		
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of		1: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of trijury (Month, Day)			4 ∐ Nursing ry at	Home 5 Resid					
lon	Attending Phrade r death. ector: After this by the funeral of	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		/ear) Intury		rk? Yes 2∐No						
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	ne Hospit n 24 hour he Funera	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/or ir	th occurred at the ti	me, date and pla opinion, death oc	ce, and due to the c curred at the time, o	cause(s) and ma date and place,	nner as stated. and due to the o	cause(s)		
	To the comp	Σ	29b. Signature and title of certifier	/-		29c. Licens			29d. Date signed	d (Month, Day,	Year)		
•	\mathcal{O}_{i}		Mill Cll	my mo			7725	/	August	4,2	004		
	/		30. Name and address of person who	completed cause of dea				Colum	bic n	ND 71	044		
	Sta	ate	31. Date filed (Month, Day, Year)	2: Registrar		, CE 000	CIVIE	C5 (0 M		, (1	0 7 7		
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			1 - For State Registrar	State of Ma	-	artment of He			iene •g. Ng. () ()	1. 4	25001
		- 0	Decedent's Name (First, Middle, Las	it)				2. Date of Deat	th	-7	3. Time of Death
	Physici		SOCORRO BALAN					Month &		Year	2:49 PM
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death		4c. County of	_	<u> </u>
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	Funeral		5. Social Security Number 6 Se	9x 7. Age □M 2XTF	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpla	ace (State or Foreign
	Director		215-98-0907 Usual Residence of Decedent	83	Yrs.			12/21/1	920		PPINES
	land		10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
	Mary -1 sh	ţō	MD BALTIMO	ORE	PERRY F	ALL.					1 ☐ Yes 2 ☐ XNo
	r 28e	Director	10e. Street and Number			10f. Zîp Code		1	0g. Citîzen of W	hat Counti	ry?
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	ems dear	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	ecify Yes or No-		- America White, e	
36	or It	by Fu	1 Never Married 2 Married	1 ∐ Yes 2 ∏x No If Yes, Give		1 □ Yes 2y⊡ No	Specify:	, , , , ,	Specify:		
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<u>lar</u>	should be and Mental marked o	ToE	EPIPANIO CALINAV	<i>I</i> AN			MARIA G	UIJANO			
Maryland	and and sum		19a. Informant's Name/Relationship (7	Type, Print)		ing Address (Street ar				itate, Zip (Code)
	1 and 2 Health Iem 27		LUCITA HERRERA	DAUGHTER		GERST ROA					
0	0 0 == ==		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place,) !		20c. Location - C		
Baltimore,	permit. Pag Department Important: I any injury o		`4 □Donation 5 □ Other (Specify		DULANEY V	ALLEY MEM. 2. Name and Address	YAD		COCKEYS		•
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			23a. Part. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the					ISON, MD		∠OO Approximate
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Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnancy □ Other (specify)			Mont		y Day Year
Ö	that the de led by the a detached t	Physicia	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unknown		(4, 55),		ave			
σ.	The law requires that the te has been signed by the bage 2 should be detached.	by P	Part II. Other significent conditions co	ontributing to death but			in Part I.	23e. Did tob	acco use contrib	ute to the	cause of death?
ğ	w require been sig should b		CEREBRO VAS	CULARS	ACCID	ENT		1 □ Ye	s 2 100 3	☐ Probab	bly 4 □Unknown
Vital Records,	e law requ has been je 2 shoul	Completed						24e. Was ar		ere autops	sy findings available
Ä	The late has page	mo:						autops perform	ned? de	ath? Yes 2	pletion of cause of
ita	certificat ector, p	Be C	25. Was case referred to medical examiner?				26. Place of Death				
ot <	ys diib	No.	1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Outpatie	nt 3 DOA Other	4 Nursing Hor	ne 5 🗆 Reside	nce 6 Other	(Specify)	
		on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work?	_	28d. Describe ho	w înjury occurred	1	
<u>sio</u>	ten feat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		A.1 /		es 2□No	201 1 11 10			
Division	I or Attendated after death	ertification;	4 ☐ Homicide determined	building, etc.	y - At home, farm, st (Specify)	reet, factory, office	2	City or Town	reet and Number , State)	or Rural I	Route Number,
	e Hospitel 24 hours a E Funeral C etely filled	O	29a. Certifier 154 Certifying Phy	ysicien: To the best of	my knowledge deal	th occurred at the time	date and place, a	and due to the ca	use(s) and man	nor as stat	tod
	To the Hospitel or At within 24 hours after of To the Funeral Directompletely filled in by	edical		niner: On the basis of e	xamination and/or in	vestigation, in my opin	nion, death occurre	ed at the time, da	ite and place, an	d due to ti	he cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. License	number	25	9d. Date signed (Month, Da	ay, Year)
	1/1		150000	tion in S		D	3027-	2	Augus	57 0	16,2004
6	1		30. Name and address of person who			D : .)					
/	V	79	THOMAS S.	MILLER		MAIDEN	1 CHOICE	E LANG	BAZTIO	nece	, MO 21228
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar	s Signature	mile!					

SOCORRO

.ln€	Brune		For State	State of Maryla	-	artment of H rtificate of L			21101	25095				
			Registrar 1. Decedent's Name (First, Middle, L	.ast)		timodio or E	Joann	2. Date of Death		3. Time of Death				
	Physic		PAULTNE BON	SUK BRUNE				Month August	08, 2004	1 18:14 ^M				
	/Medi Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Death	riagast	4c. County of Deal					
1			Franklin Squar	e Hospital		Roseda	ale		Bali	imore				
	Funeral		Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)				
	Director		213-72-7427	1□M 2 S F 4	7 Yrs.		110013	January	4,1957 N	Maryland				
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits				
	Aaryli Fsho	ō	Maryland Balti	more	Down	ry Hall				1 ☐ Yes 2 No				
	28e-	Director	Maryland Balti 10e. Street and Number	more	ren	10f. Zip Code		10	g. Citizen of What Co					
	aa or	<u>=</u>		as Pood			1128			,				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Madical Examinar must be notified at Once.	Funeral	5004 Hilltop Acr	12. Was Decedent Ever in	u.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	U.S.A. 14. Race - Ame					
36		by Fur	1 Never Married 2 Married 3 Widowed 4 Minimarried	Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2 No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White Specify: White	•				
21215-0036	tura stura		15. Decedent's		16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business/	Industry				
215	77 nin 72	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired;	luring most of worki)	na	Industrial	*				
212	d with	E	12	2	er		Compa	ny						
	al Hy s othe	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, M	aiden Sumame)					
yla	Ment Ment arkec	으	Michael	Bonsuk			Janet	Lorrain	e Munyan					
Maryland	2 she and land land	or i	19a. Informant's Name/Relationship		1	•			City or Town, State, 2					
	l and fealth im 27 her ti		Shelley D. Teter 20a. Method of Disposition	(Sister)					, Maryland					
Baltimore,	iges 1		1 Burial 2 □ Cremation 3	LINGINOVALITOIN State		sition (Name of matory or other place	1	4) -	0c. Location - City or	Iown, State				
ţ	it. Paurtmen intant: njury	1	`4 □ Donation 5 □ Other (Spec	100		L1 Cemeter		-04 <u>B</u>	altimore,	Maryland				
Bal	Depar Depar Impor any ir		21. Signature of Euneral Service Lic	Tommer		2. Name and Addres Cully-Pol 30 E. Fort		neral Ho	me P.A. re, Maryla	and 21230				
			23 Part 1. Enter the disease, or co- shock, or heart failure. List on	molications that caused the de y one cause on each line.	eath. Do not ent	er the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between				
	Priysician		mmediate Cause (Final disease or condition	. Multiple	inner	16				Onset and Death				
	/Medical Examiner		resulting in death)	Due to (or as a cons										
В	cate be executed physician and the burial-transit	Ļ	Sequentially list conditions,	b. Due to for as a cons	on and									
		nine	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a cons	duence or									
		Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):									
8760,	siciar siciar	dicai E		. 4										
687	ificate g phy as the	0		U										
Вох	death certific e attending p id for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred		75			23d. Date of deli	very				
		icia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)	1 Live birth 2 Fo		Ectopic pregnancy Other (specify)			Month	Day Year				
P.0	at the by th	hys	9 X Unknown	9∐ Unknown										
	es De	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause give	n in Part I.		cco use contribute to					
ord	w requir been si should	ted						1 ☐ Yes	2½ No 3 □ Pro	bbably 4 Unknown				
Records,	The law i ate has be page 2 sh	Completed						24a. Was an autopsy performe	prior to o death?	topsy findings available ompletion of cause of				
_		a	25. Was case referred to medical				26. Place of Death	(Check only one)		2□ No				
<u>></u>	Physiclan: this certificatal director,	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2	C ER/Outpatien	t 3 DOA Othe		1	ce 6 Other (Spec	ufv)				
	g Ph er th	Į.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28h Time of		at 2	28d. Describe how	injury occurred	* * **				
Division	Attending I ir death. ector: After by the funer	Certification:	1 □ Natural 5 □ Pending 2 ② Accident investigation	on August 8,2004		P M 1□Y	es 2.5MNo	driver of	1 vehicle	nking				
ivis	I or Attendi after death. Director: A I in by the fu	tific	3 ☐ Suicide 6 ☐ Could not determine	be d 28e. Place of Injury - Al building, etc. (Spe	t home, farm, str	eet, factory, office		City of Tour	et and Number or Ru.					
Ö	itel or rs afte ral Dire	Cer			heet		/	tall field 1	Manor Dy at more Count	Hellseld CT				
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai		hysician: To the best of my keminer: On the basis of exami and manner stated.				ind due to the cau	se(s) and manner as	stated.				
	To the within To the Comp	M	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Month	, Day, Year)				
•	*		Jastar Sh	eenherg M	2	0.0	C.M.E.	I	August 09,	2004				
	10		30. Name and address of person who	completed cause of death (II	tem 23a) (Type,		mot Ball	-imores -	formuland 2	1201				
			Tasha Z Giree	nberg M.D.		0		rmore, r	Maryland 2	1201				
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 0 2004 32 Registrar's Signature											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Tave 1:30 Bradi 04 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltinore
If Under 1 Year If Under 24 Hrs. Baltimore of Maryland 6. Sex Medical System 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2ØF 214 - 44 - 9442 Days Months Hours 5 26 1946 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Baltimore N/A 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? U.S.A. 1711 Clarkson Street 21230 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Bloomers Tavern 11 Barmaid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert G. Sparks Ruby L. McElrov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39 Panorama Lane, Hanover, Pa. 17331 Ruby A. Piazza (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem Gardens 08-13-04 Sykesville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Hours Immediate Cause (Final myocardia infantion sease or condition resulting in death) Due to (or as a consequence of): contic anyeurysm abdomina Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? extremity ischemia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Funeral

Director

item 27 is marked other than "natural", or Iteme 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Iter any injury or other treumatic event, It a Medical Exercition

Baltimore, Maryland 21215-0036

the Maryland

with

death

burial-transit as the t

Examiner Physician/Medical ð Completed 2 Certification:

Medical

IF FEMALE:

29a. Certifier

been signed by the attending physician Box 68760 P.O. Division of Vital Records, o the Hospitel or Attending Physicien: this After after death. filled in by within 24 hours a

autopsy performed 1 Yes 2/2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 12 Inpatient 2 EN/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

on/monary

Medical center

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

Charle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stefan

obstructive

-hock University AUG 1 0 32. Registrar's Signature

MD417985

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death . Decedent's Name (First, Middle, Last) 1700 Year **Physician** Harold F. Browning /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea **Examiner** AGNE 7MONE If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year 10/21/1917 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year Birthplace (State or Foreign Country) **Funeral** Davs 165M 2□F MD Director 212-10-3496 86 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a, State 10b. County r 28a-f show 10d. Inside City Limits 1 ☐ Yes 2 No Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or items 23a or Examiner must be ā 21228 USA 2022 Cedar Circle Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ 3 Widowed 4 □ Divorced White "natural" ed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complete Elementary/Secondary (0-12) College (1-4or 5+) 12 Human Resource Manager PPG Industries 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental Edith Fuhrer Willaim Frank Browning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if item 27 ia any injury or other trau once. 21014 Bel Air, MD 1024 Quince Lane Lynne Florio/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 S Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 08/06/2004 Baltimore, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc, /36 Edmondson Ave. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** UNICADUM /Medical Due to (or as a consequence of) 3 | Ectopic breagning of presoned by Medical Examines

1 undern: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a nonsequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Dav Year 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No. o the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes Completed OCCIPITAL FRACTURE SEVERE ADRIC STENOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION certificate 1 ☐ Yes 2 X No 1 Yes 2 X No BILATERAL FREMAD THORAY of Vital 25. Was case referred to medical examiner?

1 X Yes 2 □ No Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Division Hospital or Attending 1 Natural FELL AMO STRUCK HEAD ON A 1 ☐ Yes 2 No 26 2004 UNKNOWN 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2.2 CEDAL CIR CLE DR Director; 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide AT HOME within 24 hours a To the Funaral D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ledical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P18620 AUG 02,2004 male Taramella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAWALI BALTIMORE MO 21229 JARANILLA 900 CATON AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

AUG 1 0 2004

Stephen H. Burkard For State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Stephen H. Burkard 4. 2004 0600 a August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 7027 Arundel Mills Circle Hanover 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 ☑ M 2 ☐ F 087-28-5908 68 Jan. 16, 1936 New York Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow. the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 28a-f 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ death with 7555A.Weather Worn Way 21046 238 USA Completed by Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after □XYes 2 □ No Yes, Give 1 Never Married 2 Xiarned 1954 Maryland 21215-0036 1 ☐ Yes 2 💆 No white Specify: 3 ☐ Widowed 4 ☐ Divorced 1957 Year or Dates: neturel', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) President Systems. Inc other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Pages 1 and 2 should be f nent of Health and Mental P ent: If item 27 ie marked of Stephen Burkard Yolanda Saraceno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Burkard/wife 7555 A Weather Worn Way, Columbia, Md. 21046 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Importent: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash.Crematory 🖇 Laurel, MD. 16/04 permit. 22. Name and Address of Facilit Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Rd. Columbai, Md. 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (b) as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. P Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Ses 2 □ No 24a. Was an page 1 Yes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ို 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 POther (Specify) at scene 28d. Describe how injury occurred plantic bay. Deceased placed plantic bay. one his head 28a. Date of Injury
(Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After FOU TAS 5 Pending FOU 1 Natural 6:00 AM 1 ☐ Yes 2 No 24-04 death. 2 Accident investigation within 24 hours after deal To the Funerel Director: 6 Could not be determined 3 Suicide Homicide Location (Street and Number or Rural Route Number, 428 City or Town, State) HAMPTON INN 2m428 28e. Place of Injury - At hom building, etc. (Specify) At home, farm, street, factory, office à notel room 7027 Anudel Millscir, A.A.Co. MD Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and OCME August 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2004

DHMH 17 Rev 1/2001

Registrar

	7		TZJAGZI P	er me Go	ertificate	of Health and N of Death		Reg. No. ()	25100			
Physician		Decedent's Name (First, Middle, Last)	D.D. 4				2. Date of Dea	ath Day Year	3. Time of Death			
/Medica	1	James Lambert					August		0905 A. M			
Examiner	' '	4a. Facility Name (If not institution, give st	reet and number)			own, or Location of Death		4c. County of Dea	ith			
Funeral		4231 Wine Road 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	y) If Under 1		8. Date of Birt	Carroll	rthplace (State or Foreign			
Director		219-42-5670	M 2□ F	58 Yrs.	Months	Days Hours Min.	Sept.	22,1945 P	ennsylvania			
pu s		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location				10d. Inside City Limits			
Aaryla f eho	5	Maryland Carroll		Westm:					1 Tyes 2 ANo			
the tree	Se -	10e. Street and Number			10f. Zip (Code		10g. Citizen of What C	ountry?			
d within 72 hours after death with the Maryland sjere. If than "netural, or Items 23e or 28e-f ehow the Maryland Examinar must be notified at the Maryland by Eurara Director		4231 Wine Rd.			2	1157		U.S.A.				
ems Sermi	ner	11. Marital Status	2. Was Decedent E	ver in U.S.	3. Was Decede	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	pecify Yes or No	14. Race - Am Black, Whi				
d 2 should be filed within 72 hours after the and Mental Hygiene 27 is marked other than "netural", or it treumatic event, the Modical Examination Programming April 10 Programming the April 10 Pro	Dy FL	1 Never Married 2 Married	1 X Yes 2 □ No If Yes, Give	•	1 ☐ Yes 2		. ,	0 "	hite			
hour tural	60	3 ☐ Widowed 4 🏋 Divorced 15. Decedent's Educ	Year or Dates:	16a De	cedent's Usual	Occupation		16b. Kind of Business				
nin 72 In "ne Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		life	a. DO NOT use	,	king .					
illed within I Hygiene. other than "	E	12	College (1-401 54	T)	couble	Shooter		Baltimore	Gas & Elect			
E T # 5	ne Re	17. Father's Name (First, Middle, Last)						Maiden Sumame)				
	0	James Henry Blizza					Ester					
2 8 8		19a. Informant's Name/Relationship (Typ				Street and Number or Ru		•	Zip Code)			
1 and 2 Health tem 27	ŀ	James L. Blizzard II - son 1804 Ridge Rd. Westminster, Md. 21157 20a. Method of Disposition (Name of Date 20c. Location - City or To										
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Metro Ci	rematory or oth	er place)	2004	Baltimore,				
permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service License	9		22. Name and	Address of Facility						
permit. Departr Importe any inje	4	Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, Md. 21102 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused to	the death. Do not a					Approximate Interval Between			
Pnysician	ı,	Immediate Cause (Final disease or condition			roscler	otic Cardio	vascular	Disease	Onset and Death			
/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
	ē	Sequentially list conditions, if any leading to immediate	Due to for as a	consequence of								
nsit		cause. Enter Underlying Cause (Disease or injury that initiated events										
be executed sician and burial-transit	Examin	resulting in death) Last	Due to (or as a	consequence of):								
pur picia	200	d.										
ng phys	Med	IF FEMALE:										
leath certifical attending place as t	an/	23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of 1 Live birth 2	Fetal death	3 □Ectopic pre			23d. Date of de Month	blivery Day Year			
by the attached for	Physician/Medic	1 Yes 2 No	4□Pregnant at t 9□Unknown	ime of death	5 ☐ Other (spe	city)		Worth	Day Teal			
igned by be detac		Part II. Other significant conditions conf	tributing to death bu	t not resulting in the	underlying car	use given in Part I.	23e. Did t	obacco use contribute t	to the cause of death?			
ures d be	d by						10	Yes 2□No 3□P	robably 4 Nhknown			
w requirements	ete						24a. Was	an 24b. Were a	utopsy findings available			
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed							ormed? death?	utopsy findings available completion of cause of			
ystcien: The lis certificate hadrector, page	ø	25. Was case referred to medical				26. Place of Dea	th (Check only o		5 2 140			
Physicien: r this certifica ral director, i	10 13	examiner? 1 □XYes 2 □ No	ospital: 1 🗌 Inpatier	it 2 ER/Outpa	tient 3 DOA	Other: 4 Nursing H	ome 5 Resid	dence 6 Other (Sp	ecify) Scene			
ding Ph h. After th funeral		27. Manner of Death 1 → Natural 5 Pending	28a. Date of Injury (Month, Day)	Year) 28b. Time Injur		c. Injury at Work?	28d. Describe	how injury occurred				
Attending r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No						
or Att	Ě	4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, (Specify)	street, factory,	office	28f. Location (S City or Tox	Street and Number or F wn, State)	Rural Route Number,			
Hospitel 24 hours e Funeral (stely filled		29a, Certifier 1 Certifying Phys	ician: To the hest o	f my knowledge, de	eath occurred a	t the time, date and place	and due to the	cause/s) and manner a	e stated			
24 hos 24 hos Fun etely	Medical	(Check only one) 2 Medical Examin	er: On the basis of and manner stat	examination and/or	investigation, i	in my opinion, death occu	rred at the time,	date and place, and du	e to the cause(s)			
To the Hospitel or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			29c.	License number		29d. Date signed (Mon	th, Day, Year)			
	- 1	DIADA!				OCME		August 9, 2	2004			
		90000				OCT-III		Mudum . 7 - 7	.UU=			
		30. Name and address of person who con	mpleted cause of de		pe, Print)	Street, Ba						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2004 Berge 4:41 AM August Geraldine Reba /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Peartree House Assisted Living Anne Arundel Pasadena 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XF 216-12-9439 80 Director 2,1923 MD Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or items 23a or 28a-f ehow the Middeal Examiner must be nutified at 1 ☐ Yes 2 No Funeral Director <u> Anne Arundel</u> Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 333 Queen Anne Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Be Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) of Health and Mental Hygiene. Item 27 is marked other then other treumatic event, the Missing of the treumatic event, the Missing of the treumatic event, the Missing of the treumatic event, the Missing of the treumatic event, the Missing of the treumatic event, the Missing of the treumatic event, the Missing of the treumatic event. College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Ralph Lusby Cynthia Ridgell 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marsha Imhoff / daughter 333 Queen Anne Road, Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State HH: Pages 1 Burial 2 Cremation 3 Removal from State Aug 2004 permit. Page Department of Important: If any injury or Maryland Veterans Cem. 1 4 Dong 5 Other (Specify) Crownsville, MD of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signatu moudo 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shi ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distance or condition resulting in death) 2 weeks **Physician** neumomo /Medical Due to (or as a consequence of) **Examiner** Tulmonay disease Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed burial-transit 1abetes Due to (or as a consequence of): P.O. Box 68760, physician the 38 attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? ō Month Day 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b rector, page 2 sl autopsy performed? 1 🔲 Yes 2 No 1 Yes 2/2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient Cther: 4 Nursing Home 5 Residence 6 Mother (Specify) 11ving 1 Yes 2 No 10 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29b. Signature and title of confiner 29c. License number 2 completed cause th (Item 23a) (Type, Print) 30. Name and address Can 31. Date filed (Month, Day). 32. Registrar's Signature ear) State Registrar

			for State Registrar	State of M	laryland .		artment rtificate			and M	-	giene	004	251	02	
			1. Decedent's Name (First, Middle	, Last)							2. Date of De.	ath Day	Var		of Death	
4	Physici: /Medic		Betty Delores	Cross							AUGUS		200.	4 11:0	ØA M	
	Examin		4a. Facility Name (If not institution Saint Joseph			~	4b. City, 7	4b. City, Town, or Location of Death TOWSON				4c. County of Death Baltimore				
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last		If Under Months	Inder 1 Year If Under 24 Hrs. 8. Date of Both Days Hours Min. (Month, L.					9.1	Birthplace (State	e or Foreign	
	Director		219-50-3022	1□ M 2 XX	58	Yrs.	Months	Days	Hours		Jan. 1	4,194		st Virg	inia	
	Du ≱		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or La	cation							10d. Inside	City Limits	
	f sho	ច	Maryland Harfor	a		l Ai						1 [
	28e-i	rect	10e. Street and Number			T AL	10f. Zip	Code				10g. Citizen of What Country?				
	ges 1 end 2 should be filed within 72 hours after death with the Marylend it of Health and Mental Hygiene. If Item 27 is merked other then." natural, or Items 23a or 28e-f show or other treumatic event, the Medical Eval. In tribuil the Lodified at or other treumatic event, the Medical Eval.	0	1121 Royston Pla	ace. Apartm	≏nt K			1015				-	S.A.	,		
	ms 2	Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Nas Decedent of Hispanic Origin? (Specify Yes or N f Yes, specify Cuban, Mexican, Puerto Rican, etc.)						4. Race - A	merican Indian,		
9	or its	교	1 Never Married 2 Marri	Armed Forces ied 1 Tes 2 If Yes, Give			ryes,spec 1 ⊡Yes 2		specify:	, Pueno i	Hican, etc.)		Black, W	hite, etc.		
21215-0036	ural',	d by	3 ☐ Widowed ♣️Divorced	Year or Dates:			103 4	X_X40	эрвину.				Specify:	White		
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121	withir ane.	d L	Elementary/Secondary (0-12)	College (1-4or		abor	DO NOT us	e retirea,	1			Clos	nina	Company	,	
d 2	filed Hygir Sther ant,		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle)								(First, Middle,	Cleaning Company				
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ary	shou and M mar	-	19a. Informant's Name/Relations	nip (Type, Print)	1	19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	i Route Numbe	er, City or	Town, State	e, Zip Code)		
Σ	end 2 alth a 27 ts er trei		Janet Sue Walke	r		1121	Roys	ton	Plac∈	e, Ap	t.K, Be	el Al	Ir, Md	. 21015	5	
J. C	of He of Herr		20a. Method of Disposition 1 Burial	2 Damoual from Stat	l com	e of Dispo	sition (Nam natory or ot	ne of ther place	9)	D	ate	20c. Loc	cation - City	or Town, State		
<u><u>Ĕ</u></u>	Pag ment ent: t		' 4 ☐ Donation 5 ☐ Other (S	pecify)		riew	Crema:	tory	I	lug.	7,2004	Balt	imore	, Maryl	.and	
Baltimore,	permit. Pages 1 end 2 s Department of Health ar Importent: If Item 27 is any injury or other treu 90.09.		21. Signature of uneral Service	icensee		22	2. Name and	d Addres R	s of Facilit	y zinsk	i Fune	ral E	Tome.	PΔ		
_	40 E 8 9		15-6		-			old	Easte	ern A	venue,	_Esse	ex, Ma	ryland		
			23a: Part1. Poter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. I line.	Do not ent	er the mode	e of dying	, such as	cardiac o	r respiratory ai	rrest,		Approxim Interval 8 Onset an	letween	
	Physician		Immediale Cause (Final disease distribution resulting in death)	_a POSSIL			ì							1 DAY		
	/Medical Examiner		rosaling in doubly		s a consequen											
		-	Sequentially list conditions, if any, leading to immediate	b. BREAST	S a consequen											
	uted d ansit	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events													
ó	exec en an rial-tr	Exa	resulting in death) Last	Due to (or a	s a consequen	ce of):										
8760,	The law requires that the death certificate be executed to the been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai		d												
9	ing ph	Med	IF FEMALE:											-		
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth					Ectopic pregnancy				23d. Date of delivery Month Day		Year	
0.	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnant 9□ Unknown	at time of deat	n 5∐	Other (spe	ecify)						,		
Δ.	that the death certific ed by the attending p detached for use as	by Physician/Me	Part II. Other significant condition	ons contributing to death	but not resultin	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	se contribute	to the cause o	f death?	
Records,	uires tha signed I Id be det	d b									1 🗆 🕆	Yes 2	No 3□	Probably 4	ÛUnknown	
Ö	w require been si should I	lete									24a. Was	an	24b. Were	autopsy finding	s available	
Re	t iclen: The lav certificate has rector, page 2	Completed									autor perfo	osy rmed?	prior death	to completion of ?	cause of	
of Vital		BeC	25. Was case referred to medical						26. Place	of Death	(Check only o	2 No	1) (Y	es 2□No		
*	S S	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpai	tient 2 ER	/Outpatier	nt 3 DO	A Othe			ne 5□Resid		Other (S	pecify)		
0	ng Ph ter th	ü.	27. Manner of Death 1 Watural 5 ☐ Pendin	28a. Date of In	jury 28 ay Year)	b. Time o	28	8c. Injury Work	at		28d. Describe					
<u> </u>	Attending or death. ector: After by the fune	atic	2 Accident investig	gation		,	М		′es 2 🗆	No						
Division	or Att ter de irect	Certification:	3 ☐ Suicide 6 ☐ Could a determ	inod 286. Place of I	njury - At home etc. <i>(Specify)</i>	, farm, str	eet, factory	, office		2	28f. Location (S City or Tox	Street and wn, State)	l Number or	Rural Route No	ımber,	
Ω	Hospitel or 24 hours efte Funerel Dir tely filled in		One Confice	Obviolation T	that are to			- 4 41 :		11						
	To the Hospitel or Attending Phwithin 24 hours efter death. To the Funerel Director: After thi completely filled in by the funeral.	Medical	29a. Certifier 1 X Certifyin (Check only 2 Medical one)	ig Physician: To the bes Examiner: On the basis and manners	of examination	age, deat and/or in	vestigation,	in my op	e, date an inion, dea	d place, a th occurre	ed at the time,	date and	and manner place, and c	as stated. lue to the cause	9(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie				29c	. License	number			29d. Date	signed (Mo	onth, Day, Year))	
	- /		141	1 -				0 69	1495			8 /6	112	7/-		
	8		30. Name and address of person	who completed cause of	death (Item 23	Ва) (Туре,		- 100 To				V / .	3 I V	4		
			31. Date fied (Mohili, Dev. Year)	D. 7601 0	SLER J	RIV	E TO	402h	I, M6	RYL	AND 2	12014		/		
	Sta Regist		31-Date fled (Mohith, Day, Year) AUG 1 0 200	32. Regis	trars Signatur	A	oak	V								

			For State Registrar	ate of Maryland / D	epartment of H		, ,	2001.	25103			
			1. Decedent's Name (First, Middle, Last) 2. Date of Death									
	Physicia		James Jerome Conner	:			Month	Day Year 4 2004	6:20PM			
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or	Location of Death		4c. County of Deat				
			FRANKLIN SQUARE	HOSPITAL	ROSE D	ALE		ee				
r	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) June 15, 1	(ear) 9. Birti	hplace (State or Foreign untry)			
	Director		1/5-16-8351	83 Y	rs.		June15,1	921 Peni	nsýlvania			
-	and W	1	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits			
	daryi f sho	ō	Maryland Baltimore	Essex				1 ☐ Yes 2 X Mo				
	the 28a-	rect	Maryland Baltimore 10e. Street and Number	TODEY	10f. Zip Code		100	g. Citizen of What Co	untry?			
	3a or		1632 Williams Avenue		21221			U.S.A.	,			
	ms 2:	Funeral Director	11. Marital Status 12. W	as Decedent Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame				
0	or Ite	Ē	1 Never Married 25 Married 1	rmed Forces? □XXIs 2 □ No	4 TV APAI	in, Mexican, Puerto	Hican, etc.)	Black, White	e, etc.			
200	ral',	d by	3 Widowed 4 Divorced Y	Yes, Give ear or Dates: WWII	1 ☐ Yes 2√0√No	Specify:		Specify: W	hite			
ก็	72 h "natu	Completed	15. Decedent's Education (Specify only highest grade con	n 16a. I	Decedent's Usual Occup Give kind of work done	during most of work	ing 16	6b. Kind of Business/	Industry			
7	han han	Ig I		ollege (1-4or 5+)	life. DO NOT use retired	,		Construct	ion			
7	Hygie ther t		17. Father's Name (First, Middle, Last)	LTI	nish Carpent		e (First, Middle, Ma	Construct	TOII			
and	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene. If Mary 1 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ittu Marylaal Eratti and must be maillied at	o Be	James Oscar Conner			Molly Ba		iliden Gamame)				
<u> </u>	shoul mark mati	၉	19a. Informant's Name/Relationship (Type, P	Print) 19b.	Mailing Address (Street			City or Town, State, 2	Zip Code)			
Z	Ith ar 27 is r trau	7 9	Michael Besche (Son-		2 Shawn Cour							
ō,	s 1 and Hea		20a. Method of Disposition	20b. Place of	Disposition (Name of r, crematory or other place			c. Location - City or				
Ē	Page: ent or ht: If ry or		Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	vai from State	s Of Faith	· 1	7. 2004 B	altimore,	Marvland			
аппо	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Fondral Service Diseases	Surden	22. Name and Addre							
ñ	Deparation of the control of the con	1	7966		1407 01d	Bruzazınsı Fastern A	kı Funera Avenue, F	I HOMe, P Ssex. Mar	.A. yland 21221			
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death. Do n					Approximate Interval Between			
١,	Physician		Immediate Cause (Final disease or condition		ATHMIA				Onset and Death			
	/Medical		resulting in death)	Due to (or as a consequence of								
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-	p ∉	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):							
	scute ind trans	Examiner	Cause (Disease or injury that initiated events c									
Ď	oe execian a		resulting in deathy cast	Due to (or as a consequence of	f):							
8/60	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	dical	d									
٥ ×	leath certific attending p	/Ме	IF FEMALE:	yes, outcome of pregnancy								
X Q Q	atten for us	ian	in the past 12 months?	Live birth 2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	,		23d. Date of del Month	rvery Day Year			
o.	the de	Physician/Me		Unknown	3 Cirler (specify)							
J.	that the de sed by the a detached	y Ph	Part II. Other significant conditions contribu	ting to death but not resulting in	the underlying cause giv	en in Part I.	23e. Did toba	.cco use contribute to	the cause of death?			
Records ,	w requires that been signed to should be det	d by					1 🗌 Yes	2 No 3 □ Pr	obably 4 Unknown			
<u></u>	w red beer	ompieted					24a. Was an	24b. Were au	itopsy findings available			
	sician: The law certificate has b irector, page 2 st	шс					autopsy perform	prior to death?	completion of cause of			
		O	25. Was case referred to medical			26 Place of Deat	1 Yes 2	No 1 Yes	2□ No			
<u> </u>	Physician: r this certific ral director,	0.0	examiner? 1 ☐ Yes 2 No Hospi	tal: 1 ☐ Inpatient 2 X ER/Out	patient 3 DOA Oth	0.0		ce 6 Other (Spe	cify)			
o	en or or	L:		Ba. Date of Injury 28b. T		v at	28d. Describe how		,/			
ō	ath. eth. er: Aff	atio	1X Natural 5 Pending 2 Accident investigation	(World, Day You)		Yes 2 □ No						
Division	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	Be. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office		28f. Location (Stre	et and Number or Ru State)	ıral Route Number,			
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	Hosp 4 ou Funei	edical	Check only 2 Medicel Exeminer:	n: To the best of my knowledge On the basis of examination and	, death occurred at the tire.	ne, date and place, pinion, death occur	and due to the cau	se(s) and manner as	stated. to the cause(s)			
	To the Hc spital or Attending within 24 ours after death. To the Funeral Director: After completel filled in by the fune	Med	29b. Signature and title of certifies	and manner stated.	29c. Licens			d. Date signed (Monta	``			
	N V		200. Gigirature and title of certains	4		055345		C/LI/nz	1			
	11)			hrs.				10/4/0				
	HX,		30. Name and address of person who complete DR. DERWIN PHILLIP	Gaco Early (Item 23a) (Type, Print)	O BAIT. W	00E 41	21237				
	Sta	ato	DR. DER WIN PHILLIP 31. Date filed (Month, Day, Year)	9CCC FRANKL	- Journe D	K. VHLIIM	UKE, MI	1 2123/				
	Regist		AUG 1 0 2004	Grava &	Sparks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
1- State Amend Item 20b per FH, G834, 08/19/04dhb
Registrar

Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** 31 5.00 P. M 04 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospita xamaritar MORE II Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth 7. Age Social Security Number 6. Sex 9. Birthplace (State or Foreign Funeral 219-38-1746 Usual Residence of Decedent Months Days Hours Min. 1 □ M 2 🕱 F Director 10a State 10h. County 10c. City Town or Location 10d. Inside City Limits 28e-f show other treumatic event, it a Medical Examiner must be notified at Maryland 1 Yes 2 No Be Completed by Funeral Director IMORR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? dere 2 Items 23a 12 Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1□Yes 2⊠No Specify 3 XWidowed 4 □ Divorced neture 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kathleen unk 19a. Informant's Name/Relationship (Type, Print) (Social 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 item 27 i 1aZa 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/23/04 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: if any injury or once. *4 □ Donation 5 □ Other (Specify) arme 22. Name and Address of Facility OSeph L, Rus 21. Signature of Funeral Service Licenses Joseph L. Russ Funeral Home 12222 W. North Ave. Balto. Md. 21216 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart fallitre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician willes disease or condition resulting in death) /Medical Due to (a) as a consequence of): Examiner Due to (or as a consequence of wills Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): the IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 🗌 Yəs Viital 2 🗆] Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA of this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division Hospitel or Attending Natural 2 Accident 5 Pending death. 1 Tes 2 □ No investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 | Homicide to 24 hours after the Funerel Directory 29a, Certifier 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi Discontinuous Physician: 10 ms best of my knowledge, seam occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29c. License number 29b. Signature and title of certifier Martha faynumlo

Registrar

DHMH 17 Rev 1/2001

MARTHA

31. Date filed (Month, Day, Year)

doch

32. Registrar's Signature

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

EMMUNI-

AUG 1 0 2004

			For	State of Marylan	d / Departme	nt of Health and	Mental Hygiene	Log.D.c.	
			1 - For State Registrar		•	te of Death	Reg. No	2001.	25105
	Physicia /Medic		1. Decedent's Name (First, Middle, L	ovington			2. Date of Death Month Da HUGUST	1 2004 c	3. Time of Death 225 Q M
7	Examin		4a. Fecility Name (If not institution, g	1 11	4b. City	, Town, or Location of Deat	h 40	c. County of Death	
				Sex 7. Age (In yrs.	last birthday) If Under	FINIOR C		9 Birthpler	ce (State or Foreign
	Funeral Director		216-32-8015	10M 20F 70	Yrs. Months		AUG. 6. 19	111 11 ~	ce (State or Foreign
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location			100	I. Inside City Limits
	Maryla -f shov lied at	tor	Maryland N/	A 7	Záltimi	nre.			1 No 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: If itsm 27 is marked other than "natursi", or items 23a or 28a-f show important: If itsm 27 is marked other than "natursi", or items 23a or 28a-f show pray injury or other traumatic svent. The Medical Exaturer must be notified at ances.	lrec	10e. Street and Number	^	10f. Z	ip Code	10g. Ci	itizen of What Country	y?
		Funeral Director	1818 Clift	on Ave.	G 40 W - D-	21217	Sanati Van av Na	14. Race - American	Indian
	ter de items	Fune	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No	If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc	
2-0036	rsi', or	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: Bla	cK
50	"natu	letec	15. Decedent's (Specify only highest of	Education rade completed)	16a. Decedent's Us (Give kind of w life. DO NOT	rork done during most of wo	rking 16b. F	Kind of Business/Indu	stry
77	filed within Hygiene. ither than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mais	d		Motel	
Maryland 2121	be filed ital Hygi id other svent.	Be C	17. Father's Name (First, Middle, Lat	st)		18. Mother's Na.	me (First, Middle, Maide	n Sumame)	1
yla	should to a Ment warked umaric a	2		een	ARL 14-70 . A 44-7	Dore	othy Mi	ae al	00
Z Z	d 2 st lth and 27 is n traun		19a. Informant's Name/Relationship	(Type, Print) (Sister)	2018 A	S (Street and Number or R	Alle Ta	or rown, state, 210 C	21217
Je,	of Heelth itsm 27 other tr		20a. Method of Disposition		Place of Disposition (No cemetery, crematory or	ame of other place)	Date 20c. L	ocation - City or Town	n, State
Baltimore,	permit. Pages 1 ai Department of Hee Important: If itsm any injury or otha once.		1 🖾 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spec	city) V	t. Zion	8/18	2/2004 La	insdow	ne, Md.
Ball	permit. Depart Import eny inj once.		21. Signature of Funeral Service Lic	ensee & RIII	Joseph Joseph	and Address of Facility	Funeral	Home 2	1216
	40.4		23a. Party. Enter the disease, or co shook, or heart failure. List on	mplications that caused the deat	th. Do not enter the mo	ode of dying, such as cardia	c or respiratory arrest,	lr.	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	. Sepsis					Onset and Death
h	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):				
	- 0	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				···
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cardiac C	ARREST				
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687	ificate g phys			<u> </u>	7 7 7 1 1				
Вох	death certificate be executed e attending physicien and id for use as the burial-transit	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta		pregnancy		23d. Date of delivery Month D	ay Year
.O.	0 0	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	death 5 Other (specify)		Month D	ay real
<u>α</u>	The law requires that the de ite has been signed by the bage 2 should be detached	by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Vital Records,	w require: been sig should b	ed b	HYPOTHYRO)			1 ☐ Yes 2	2 □ No 3 □ Probab	oly 4 Unknown
ecc	e law n has be je 2 sh	Completed					24a. Was an autopsy	prior to comp	y findings available pletion of cause of
a H							performed? 1 ☐ Yes 2 D N	death?	□ No
Z.	Physician: This certificate al director, p	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3 [Other	ath (Check only one) Home 5 Aesidence	6 □Other (Specify)	
υof	ng Phy ter thi	H-	27. Manner of Death 1 ☑ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju		
Sior	tendir leath. tor: Af the fur	catic	2 Accident investigat 3 Suicide 6 Could no	ion	М	1 ☐ Yes 2 ☐ No	206 1 206 1		3
Division	Hospital or Attending 44 hours after death. Funeral Director: After tely filled in by the funer	Certification:	4 Homicide determine			огу, опісе	28f. Location (Street a City or Town, Sta		House Wumber,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (Physician: To the best of my kni aminer: On the basis of examina and manner stated.					
	To the I within 2 To the I complet	Mec	29b. Signature and title of certifier	and manner stated.	2	9c. License number	29d. D	ate signed (Month, Da	ay, Year)
	- s + o		> Poblet 1	ela		89541	8,	16/84	
	\		30 Name and address of person wi	no completed cause of death (Ite	m 23a ype, Print)	10	cal the	Just	
	Sta	ata	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature Z	12 57618	THE THE		
	Regist		NIC 1 0 2	he was	10 100	war			

DELLA A. CARTER 4-05062 Unpend item #23a 27 per MR G834, 8/27/04 TT
State of Maryland / Department of Health and Mental Hygiene RKD 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day} 4, 2004 Year **Physician** AUGUST 11:06P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST.AGNES HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Months Days Hours 1 ☐ M 200 F 24-94-058 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland 1 Yes 2 No Be Completed by Funeral Director nore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 2 Itema 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 'natural', 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other It any Injury or other traumatic svent, ILLS Once. 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 19a. Informant's ame/Relationship (Type, Print) days hter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 20b. Place of Disposition (Name of cometery, crematory or other place) Timber Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State SON TOILS: 22. Name and Address of Facility * 4 ☐ Donation 5 ☐ Other (Specify) Garr 21. Signature of Funeral Service Licenses uneral Hoi Home Ave. 21216 Md W. North Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Cardiovascular Disease Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy jo Month Day 5 Other (specify) signed by the a d be detached for 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? cate has l page 2 s 2□ No 2 🗆 No es Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 2 1 XYes 2 ☐ No 1 ☐ Inpatient 2X ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1X Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation М I Director: And in by the fr death 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Direct 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2X Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. AUGUST 5,2004 30. Name and address of person who completed on se of death (Item 23a) (Type, Print) MEODORE MIKE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2004

GORDON CLARK

			Plea	se Type or Pr State of N						•		•			
			1 - For State Registrar	State of N	viai ylanu i		tificate o			ена пу	Reg. No	1001	25107		
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	/Medic	al	Gordon A. 4a. Facility Name (If not institution		ar)		4b. City, Towr	or Location	of Dooth	AU6U57		2004 County of Death	0820 M	_	
	Examin	ier		IAL HOSPIT			•	ASTO			40	TALE			
	Funeral Director		5. Social Security Number 212-28-0141	$2-28-0141$ $1 \bowtie M 2 \square F$ 74 Yrs. Months Days Hours Min. (Month, Day, Ye) $July 16, 1$											
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28e-f ehow ont, the Marical Examiner must be notified at	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d. fnside City Limits 1 ☐ Yes 2 ☑ No	_		
	the M	Directo	Maryland Wor	rcester	Ocea	an Pir	10f. Zip Code	9			10g. Ci	. Citizen of What Country?			
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	tems	Funerai	11. Marital Status	12. Was Deceder Armed Forces	s?	13. W	/as Decedent of Yes, specify C	of Hispanic Ori uban, Mexical	igin? (Spe	cify Yes or No Rican, etc.)	0-	14. Race - Amer Black, White			
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5	72 ho	eted	15. Deceden	it's Education st grade completed)	1	6a. Decede	ent's Usual Oc	cupation ne during mos	t of workii	ng	16b. K	Kind of Business/I		_	
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2	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any injury or other traumatic event, II and once.		19a. Informant's Name/Relations Pamela Burke (N									or Town, State, Z Maryland	•		
e,	of Hea of Hea of Item		20a. Method of Disposition 1 № Burial 2 □ Cremation		com	e of Dispos	ition (Name of atory or other p	===		ate		ocation - City or T		_	
airimor	Page tment tant: ff		`4 □Donation 5 □ Other (S	Specify)			Mem. P		8/9/0			timore, 1	Maryland		
מ	permit Depar Impor any in		21. Signature of Funeral Service	Licensee		Mc	Name and Ad Cully-	Polyni	ak Fu	neral	Home	e, P.A.	21122		
F			23a. Part. Enter the disease, or shock, or heart failure. List	r complications that caus	sed the death. [aryland	Approximate	_	
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νς Γ	is that the pred by the e detache	by Ph	Part II. Other significant conditi	ons contributing to death	n but not resultin	ng in the un	derlying cause	given in Part I		23e. Did	tobacco	use contribute to	the cause of death?		
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01 V	ding Physician: Atter this certific funeral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Impa			3 DOA	Other: 4 🗆 Nu				6 ☐Other (Spec	ify)		
סחס	ding P h. After t funera	tion:	27. Manner of Death 1 Natural 5 Pendi	28a. Date of Ir (Month, I	njury Day Year) 28	lb. Time of Injury		njury at Vork? Yes 2		28d. Describe	how inju	iry occurred			
UIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	ertification:	2 Accident investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At home etc. (Specify)	, farm, stre				28f. Location (City or To	(Street al	nd Number or Ru e)	al Route Number,	_	
_	fospital t hours a uneral l siy filled	edical Ce	29a. Certifier 1 Certifyii (Check only 2 Medical	ng Physicien: To the be Examiner: On the basis	st of my knowle	dge, death	occurred at the	e time, date an	nd place, a	and due to the	cause(s	s) and manner as	stated.	-	
	o the l	Medi	29b. Signature and title of certific	and manner	stated.			ense number				ate signed (Month		_	
	⊢ s ⊢ δ		- Me	7 Mer			0	328	87			8/6/07	P		
	bx \		30. Name and address of person	who completed cause of	of death (Item 23	(Type, F	rive S	uite *	5,8	astor	n	10 214	D		
	Sta Regist		31. Date filed (AOUG Day, Vear	2004 32 Aegi	strar's Signature		Space								

DHMH 17 Rev 1/2001

State Registrar

Sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** tricia allahah /Medical 2009 4a. Facility Name (If not institution, give street and number) hock Trauma 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs.

Pays | Hours | Min. Medical Center of Maryland 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M XXF Yrs. Director 174-34-4916 7,1942 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Iteme 23a or 28e-f show Exercines must be notified at MD Howard Ellicott City 1 ☐ Yes XXNo Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2700 Westminster Road 21043 USA permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "netural", or Iteme 23a any injury or other treumatic event, the Medical Exercine from a 00ce. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary CPA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Frank Pascarella Carmella Iovino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ma.1043 William L. Callahan/husband 2700 Westminster Rd., Ellicott City, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Deurial 2 □ Cremation 3 □ Removal from State Columbia Mem. Park 8/09/2004 Clarksville, Md. ' 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road.Columbia, Md. 21045 Lady 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician 5 hours intractrebral hemorrhage /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause that is control cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy jo Dav 4□Pregnant at time of death 5 Other (specify) the 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1□ Yes Division of Vital 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 ☐ Yes 2 Z Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 ☐ Pending death. М 1 □Yes 2 □No investigation 2 Accident within 24 hours after death To the Funeral Diractor: the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) august 6 2004 Name and a res s of person who completed cause of death (Item 23a) (Type, Print) wolas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AUG 1 0 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 3 2004 6:30PM August Alma Mae Costen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 19,1903 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F 214-12-2395 North Carolina Director 101 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21228 U.S.A. 'natural', or items 23a 719 Maiden Choice Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or flem eny injury or other traumatic event, the Medical Examinar's ORGE. Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Beulah Hayes William L. Costen ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Rolandvue Road Baltimore, Maryland 21204 Diane Sherlok (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-6-2004 Loudon Park Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. of dying, such as cardiac or respiratory arrest Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events the attending physicien and resulting in death) Last Due to (or as a consequence of) purial-P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 nonths? ō Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknowt signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, peq 2 🗆 Ko 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? Yes 24 No certificate 1 🗌 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 20 No 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Mahner of Deal! 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide To the Hospital within 24 hours a To the Funeral I 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 J.Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) Type, Pi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State	of Maryla		artment rtificate			and M	1ental Hy	giene	004	25110
	Dhomini		1. Decedent's Name (First, Midd	lle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	ai -	John J. Codd,						.,		August	4	2004	5:40A M
	Examin	er	4a. Facility Name (If not institution		umber)				Location of	of Death		4c. C	ounty of Dea	th
			1705 Langford 5. Social Security Number	Road 6. Sex	7 Ago (In un	s. last birthday)	Balti If Under		e If Under:	24 Hrs	9 Data of Bird		altimo	
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	nylanc how		10a. State 10b. County	/	10c. 0	City, Town or Lo	ocation							10d. Inside City Limits
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36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23a or 28a-f show event, the Medical Examination must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried 1 Tyes	2 ⊠ No sive		If Yes, spec	ify Cuba	n, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	te, etc.
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Maryland 21215-0036			19a. Informant's Name/Relation			1					al Route Numbe			
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Вох	eath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	outcome of precent of birth 2 Fe gnant at time o	etal death 3	⊒Ectopic pre					23	ld. Date of de Month	livery Day Year
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	1	1	30. Name and address of person	on who completed ca	use of death (I	tem 23a) (Type	, Print)				Timon	- NA	0 21	229
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	Regist	rar	AUG 1	2004	Depers	19	Sou	at.	6	*				

		1	State of Maryland / Department State of Maryland / Department /	artment of Health and Me tificate of Death	ental Hygier Reg. f	2 11 ft la	25111
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		CONSTANTINE	CULCER	Lugast 9	2004	10/30A M
4	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number) 1	Months Dave Hours Min		ur) Coi	nplace (State or Foreign
	ס		Usual Residence of Decedent				
	nylan thow	_	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Ba-f s	Director	Maryland Howard Colu	1			1 ☐ Yes 2 🛣 No
	or 2	Dire	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Co	untry?
	s 23s	eral	8997 Buckskin Court 11 Marital Status 12. Was Decedent Ever in U.S. 13. V	21045	efy Vas or No-	U.S.A.	ican Indian
36	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Itams 23a or 28a-f show important: If item 27 is marked other than "netural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinating must be indilled a once.	by Funeral	1 XX Never Married 2 □ Married 1 □ Yes 2 XX No	Was Oecedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ☑ No Specify:	lican, etc.)	Black, White	
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Вох	death cartifii e attending p od for use as	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number		Date signed (Monta	
	T		MBral Dmul,MD	RES-000	Av	gust 4, 2	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type M. Brad Drummond Tewer I) Doctor's	RES-000 Print) 600 North Baltimore	Wolfe St e, Maryl	reet and 21	287
×	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 0 2004 32. Registrar's Signature	Sparks .			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

					d / Department of Health and Me	ental Hygier	пе
				State Registrar	Certificate of Death	Reg. N	2004 25112
		Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 5:50 P. M
		/Medic	al	CALVIN DENNIS	CARTER SR. A	10,0	
		Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. I			9. Birthplace (State or Foreign
		Funeral Director		212-52-3840 IMM 20F 50	Yrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Yea 4-0211 19.1	250 MARYLAND
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		th with the Maryla 23a or 28a-f shov	ecto	10e, Street and Number	BALTIHORE		Citizen of What Country?
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		ns 23	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.		ify Yes or No-	USA, 14. Race - American Indian,
	ယ္	or items	Ē	1 ☐ Never Married 2 Ø Married 1 ☐ Yes 2 Ø No	S. 13. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	ićan, etc.)	Black, White, etc.
	<u>8</u>	ral', c	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: BLACK
	21215-0036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 28a-f show ther than Mcdical Examiner must be ricitlised at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b.	. Kind of Business/Industry
	121	d within glene. r than	g.	Elementary/Secondary (0-12) College (1-4or 5+)	NURSING ASSISTA	اد سیدر د. ۵	JURSING HOME
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	Maryland	S E E	 - -	19a. Informant's Name/Rel-tionship (Type, Print)	19b. Mailing Address (Street and Number or Rural F	Route Number, City	
	_	and 2 alth a 27 is er tras		PATRICIA CARTER (WIFE)	2855 WOODBROO	K AVE.	BALTO, MD. 21217
	Baltimore	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 20b. Pi	lace of Disposition (Name of emetery, crematory or other place)	te 20c.	Location - City or Town, State
216	<u>Ē</u>			'4 □ Donation 5 □ Other (Specify)	ZION CEMETERY 08-1	2-04 41	ANSDOWNE, MD.
4	3alt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	22. Name and Address of Facility BRO		FUNERAL HOME
4		70 = 4 O		Keniah IV. Villa	2140 N. FULTON		ALTO. MD. 21217
,	н			23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or r	respiratory arrest,	Approximate Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			~ I week
10/		Examiner		Due to (or as a consequ	Jencerof):		
TA			er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	uence of):		
X		ie be executed ysician and e burial-transit	Examiner	that initiated events	artery disease		years
V	.09	e exer ian ar urial-t		resulting in death) Last Due to (or as a consequ	uence of):		
3	876	ate b	dicai	d			
ź	9 хо	entific ding p	/Med	IF FEMALE: 23c. If yes, outcome of pregnar			
2	Bo	eath certific attending p for use as	Physician/Me	in the past 12 months?	I death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
Y	o.	by the tached	ıysic	1 Yes 2 No 4 Pregrant at time of de 9 Unknown	3 Chef (specify)		
	ط	es that thighed by	by Pr	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
	rds	w requires been sig should be				1 🗆 Yes	2 No 3 Probably 4 Unknown
72	ecords,		Completed			24a. Was an	24b. Were autopsy findings available prior to completion of cause of
13	α.	Physician: The la r this certificate has ral director, page 2	Com			autopsy performed?	death?
0	Vital	cian: ertifica	Be	25. Was case referred to medical examiner?	26. Place of Death		
	of \	shysic this o	1º	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ I			6 Dother (Specify) HOSPICE
5	n	Jing F After funer	lon	27. Manner of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation	28b. Time of	d. Describe how in	jury occurred
3	Division	death death ctor: y the	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At ho		f. Location (Street	and Number or Rural Route Number,
CI	Οį	al or / after I Dire d in b	Certification:	4 Homicide determined building, etc. (Specify	1)	City or Town, Sta	ate)
		ospita hours unera ly fille		29a. Certifier 1 Contriguing Physician. To the best of my know	wiedge, death occurred at the time, date and place, and	d due to the cause	(s) and manner as stated.
		To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	ledical	and manner stated.	tion and/or investigation, in my opinion, death occurred		
		To To	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	,			C (80 MD)	D24170	I A	rugust 6, 2004
		\		30. Name and address of person who completed cause of death (Item	8 N. Eutawst Balti	. sa M	tugust 6,2004
		Sta	ite.	31. Date filed (Month, Day, Year) 32. Registrar's Signal		mer e	7 461
	**: **:	Regist		AUG 1 0 2004 Bentua	5 Spall		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #8 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year

4:25 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☐ No

2004

1950

14. Race - American Indian,

Black, White, etc.

SpecifyBlack

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

Month **Physician** Jesse Counts, Jr. AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMURE CITY
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. BALTIMORE SINAT HOSPITAL OF 8. Date of Birth 9/2/1950. Birthplace (State or Foreign (Month, Day, Bar) 5. Social Security Number 216-54-4110 7. Age (In yrs. last birthday) **Funeral** 1√2 M 2 □ F Director 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "naturel", or Items 23a or 28a-f ehow olical Examinar must be notified at Maryland Baltimore Baltimore Director 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 21207 USA 2850 B Gatehouse Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ❖☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 then Elementary/Secondary (0-12) College (1-4or 5+) Class Machinist Coppers 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Mental is marked Thelma Reddick Jessie Counts, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 2675 Gatehouse Drive Baltimore, Maryland 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Important: if Item 27 is any injury or other trau Adria Wilson/ Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a Method of Disposition woodlawn Cemetery X□Burial 2□Cremation 3□Removal from State
'4□Donation 5□Other (Specify) 8/6/04 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd baltimore, Md 21215 Hers 23a. Part1 Inter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician CARDIAR ARRHYTHMA /Medical Due to (or as a consequence of): **Examiner** DILATED CARDIOMYOLATHY TO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ENDU CARNITIS Completed 24a. Was an autopsy performed? Yes 25 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) uneral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 □ Yes 2 □ No 2 Accident investigation 6 Could not be To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 M). AUG, 2 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAMAMAN SINA HOSPITAL OF BALTIMORE RAMJANT MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2004 Registrar

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		•	For State Registrar	State of Marylan	•	artment of H			ene . NO O O I.	25111
50 10 10 10	Physicia	an	1. Decedent's Name (First, Middle, Last) RONALD	- 6	- AR	DEY		2. Date of Death Month	Day Year 200 Y	3. Time of Death
)	/Medic Examin	3.0	4a. Facility Name (If not institution, give s No RTH いそにて	treet and number)		4b. City, Town, or		^	4c. County of Death Baltimore	9.
	Funeral Director		5. Social Security Number 220-30-6185 6. Sex Usual Residence of Decedent	7. Age (In yrs.	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	^{9. Birthol} <i>County</i>	**
	Maryland	tor	10a. State 10b. County Maryland N/A		y.Town or Lo Baltim				10	0d. Inside City Limits 1∰ Yes 2 □ No
	ath with the Marylan 123a or 28a-f show ust be notified at	al Director	10e. Street and Number 4554 Finney Ave	enue		10f. Zip Code 2121	5	100	g. Citizen of What Coun	ry?
036	urs after deat al', or Items	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U Armed Forces? □ Yes 2 □ No If Yes, Give Y Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, 6	elc.
21215-003	should be filed within 72 hours after death with the Maryland nd Mental Hygiene i marked other than "natural" or items 23a or 28a-f show umatic event, it a Modical Exercitier: stat the modified a	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	DO NOT use retired	during most of workii f)	Ba	altimore (ousing Aut	City
Maryland	should be filed within ond Mental Hygiene. marked other than amatic event, If a M.	To Be C	17. Father's Name (First, Middle, Last) Thomas Robert Ca	arney			18. Mother's Name Evelyn	B. Will	iams	
Š	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke any injury or other treumatic: ance.		19a. Informant's Name/Relationship (Tyr Rhonda Carney 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	20h I	1226	Autum	Leaves C	t Balti	City or Town, State, Zip More, Man Co. Location - City or To Itimore,	cyland wn, Slate
Baltimore,	permit. Pag Department Importent: any injury once.		4 □ Donation 5 □ Other (Specify), 21. Signature of Funeral Service License	Gr 	2	Name and Addre	ss of FacilityCha	tman-Ha	rris Fune ltimore,	eral Home
	Physician /Medical Examiner	er	23a. Party Enter the disease, or complished, or head failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		quence of):				esease	Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):					
.O. Box 6	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3	□Ectopic pregnanc □ Other (specify)	1		23d. Date of delive Month	ory Day Year
<u>а</u>	w requires that the sbeen signed by th should be detache	þ	Part II. Other significant conditions con ルのハーエルリンしん	- 1		underlying cause giv	ren in Part I. Melli NS		accoluse contribute to the 2 No 3 Prob	ne cause of death? ably 4 Unknown
Reco	The law ate has b page 2 si	Completed						24a. Was an autopsy perform	ed? prior to cor	psy findings available mpletion of cause of 2 No
Division of Vital Records,	ng Physician: Mer this certific Ineral director,	To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpalient 2 ☐ 28a. Date of Injury (Month, Day Year)		of 28c. Inju		me 5 Resider Resider 28d. Describe how	nce Other (Specify	, Energy
Divis	tel or Atte s after des el Directo ed in by th	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, s hify)	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical	(Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.		nvestigation, in my	ppinion, death occurr	ed at the time, da	te and place, and due to	the cause(s)
	To To Com	Σ	29b. Signature and title of certifier	M-D			56430		d. Date signed (Month,	2004
				URI POAD	Rond	all stu	many,	CAND		
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG. 1 0 2004	32. Registrar's Sign	Spa	eks				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

				Olato of Mai	=	Certific			Wichtan Try	Reg. No	01.	25115
	Di		1. Decedent's Name (First, Middle, Last,						2. Date of De		Your	3. Time of Death
	Physicia /Medic		Anne E.	Car					HUGUST	- 5"	2004	830AN
	Examin		4a Facility Neme (If not institution, give	street end number)				4b. City, Town, or	Location of Deeth			
			C'opper Ridge					Sykesi	ille	Cari	ro11	
4.	Funeral		5. Social Security Number 6. Sec	7. Age (i	n <i>yrs. lest bir</i>	thday) If Un Monti	der 1 Year hs Days	Hours Mir	Month, Da	h y, Ye <i>ar</i>)	9. Birthplac Country	ce (State or Foreign
22	Director		220-05-2452 Usual Residence of Decedent		,	115.			03/10/	1916	MARYÍ	JAND
	land		10a. Stete 10b. County	10	Oc. City, Town	or Location					100	I. Inside City Limits
	Mary	ō	MD CARROLI	L	SYKE	ESVILI	Æ					1 □ Yes Z⁄□ No
	r 28e	rec	10e. Street end Number			10f.	Zip Code			10g. Citizen of V	Vhat Country	P
	h with	ai D	710 OBRECHT RO	AD			21	784		USA		
020	72 hours after death with the Maryland natural; or theme 23a or 28e-f ahow alsel Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U,S.			lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		e - American ck, White, etc $_{:}$ WHIT	o
5-0	72 ho	ge	15. Decedent's Edu (Specify only highest grede	cation	16a.	Decedent's U	sual Occup	ation	ndrina	16b. Kind of Bu	usiness/Indu	stry
7	within ane.	Completed by	Elementary/Secondery (0-12)	College (1-4or 5+)	PE	life. DO NO	Vork done Tuse retired Δ Γ) Μ	pation during most of we d) INISTR	ΔTOR	WESTI	NGHOL	IS F
12	Hygian Hygian ther th	Cou		NKNOWN	1 1		HDN					
/land	0 4 0 ×	To Be	17. Father's Neme (First, Middle, Last) WILLIAM	F. SCHEPI	ER				ame (First, Middle, NA HITC		ie)	
, Man	d2sh thand 7 is m traum	•	19a. Informant's Name/Relationship (Type ROBIN WEISSE a	_{pe, Print)} ttorney	19b. 2 J	Mailing Addr	ess <i>(Street</i> INSYL	an <i>d Number</i> or R	AVE • WE	r, City or Town, STMINS	State, Zip C	ode) MD 21157
altimore, Maryland 21215-0020	Pages 1 an nent of Haal int: if item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of cemeter GLEN	Disposition (f y, cremetory o HAVEN	Vame of or other place	^{ce)} 08/	Date 10/2004	20c. Location - GLEN		
Balt	parmit. Pa Departmen Important: any injury		21. Signature of Funeral Service License	ACO					ENRY W. D MONKT			SONS CO.
É	<u> </u>		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do n	not enter the m	node of dyin	ng, such as cardia	c or respiratory ar	rest,	A	pproximate
And Silvery	Physician		SHOOK, OF HOSE CAMERO. LIST ONLY OF	ie cause on eech line.			ě					terval Between Inset and Death
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	s that	by P							101	es 2UNO	3 Probat	oly 4 ☐ Unknown
of Vital Records,	The law raquiras that tha daath ce ata has been signed by the attendi paga 2 should ba detachad for us:	8				v			24a. Wes a	in autopsy	24b. Were	autopsy findings
ပ္တ	s bee	Completed				_			perfor	med?	comp of dea	ble prior to letion of cause ath?
æ	Tha law ta has saga 2	E							1019	es et No	1□Y	es 2□ No
Ta	iclan: The cartificata rector, pag	Be	25. Was case referred to medical					26. Place of De	ath (Check only or	ne)		
>	Physician: rthis cartific iral director,	2	examiner? 1 ☐ Yes 2 ☑ No H	ospital: 1 Inpatient	2 ☐ ER/Out	patient 3	DOA Oth	er: 4 Virging I	Home 5□ Resid	ence 6 □Othe	or (Specify)	
	ng Ph tar th naral		27. Manner of Death (☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ar) 28b. T	ime of ijury	28c. Injun Worl		28d. Describe h			
0	Attending in death. sector: After by the funa	Satio	2 ☐ Accident investigation			М		Yes 2 □ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (S		m, street, fact	ory, office		28f. Location (S City or Town		er or Rural R	oute Number,
	urs al	ဦ										
	Hoss 24 ho Fune tely fi	edlcal	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Examin	ician: To the best of mer: On the basis of exa	mination and	death occurre Vor investigation	ed at the timon, in my of	ne, date and place pinion, death occu	e, and due to the c urred at the time, d	ause(s) and mai ate and place, a	nner as state ind due to the	ed. e cause(s)
	To the Mospital or Attending Physician: Tha I within 24 hours aftar death. To the Funeral Director: Aftar this cartificata hat completely filled in by the funaral director, paga	§ Σ	29b. Signature and title of certifier	and manner stated			29c. License			9d. Date signed		
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	h	ļ	30. Name and address of person w o cor	πριeted cause of deeth		rype, Print)	フィー	14	Ennste	200	-	
	Ctot	٥	3. Date filed (Month, Day, Year)	32. Registrar's		1. St	50/	- West	minste	- emis)	615	7
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State of Maryland / Department of Health and Mental Hygiene

					,	Cer	tificate o	f Death		Re	g. No? () (14	25116
	D		1. Decedent's Name (First, Middle					·	2	. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic			Grace	е Мае	Caines					gust 6, 20		2:50 a.
da	Examin	100	4a Facility Name (If not institution	, give street end numb	oer)			4b. City, Tow	m, or Loca	tion of Deeth	4c. County	of Death	
				enium Health &						tt City			oward
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yr	s. lest birthday)	If Under 1 Year Months Day		Min.	Date of Birth (Month, Day,	Year)	9. Birthpl Count	ace (State or Foreign try)
	Director	-	056-18-1899 Usual Residence of Decedent			83 Yrs.				February 2	2 , 1921		Florida
	fand	ŀ	10a. State 10b. County		10c. 0	City, Town or Loc	ation					10	Od. Inside City Limits
	Mary	ğ	Maryland	Howard				Columbi	ia				1 ☐ Yes 2 No
	r 28s	Director	10e. Street and Number		1		10f. Zip Code		<u> </u>	10	g. Citizen of W	hat Count	try?
	ith with the Marylar 23e or 28e-f ehow		5971 Turnabout La	ine				210	044			U.S	i.A.
	items ?	Funeral	11. Marital Status	12. Was Deced Armed Ford	ent Ever in	U,S. 13. W	as Decedent o	f Hispanic Origi uban, Mexican,	in? (Speci	fy Yes or No-		- America k, White, e	
20	w 0 5	by Fu	1 ☐ Never Married 2 Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 If Yes, Givé Year or Dat	No		□ Yes 2XN		T dono Th	ouri, oto.)	Specify		Black
21215-0020	72 hours "natural", edical Exe	<u>8</u>	15. Decedent	's Education		16a. Decede	ent's Usual Occ	upation		11	6b. Kind of Bu	siness/Ind	ustry
215	hin 7:	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4	lor 5+\	(Give k	ind of work dor O NOT use reti	ne during most (red)	of working			Educ	cation
21	The second second	ĕ	12	College (1-2	101 J+)		Die	etary Assis	tant				
P	医工士艺	Be	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (First, Middle, Ma	aiden Sumam	e)	
yla	Mer Mer affice a	٥	De	orsey Adams						Mini	nie unkno	own	
Maryland	and and	4	19a. Informant's Name/Relations	nip (Type, Print)						Route Number,	-		Code)
4	Health Health Hem 27 is	-	Ms. Christine Cu	ttino Da	ughter	Place of Dispos		bout Lane		bia, Maryla			
Baltimore,	9 t 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from St		cemetery, crem	atory or other p	lace)	Į.		0c. Location -		
tim	t. Peg trant tant: i	-	4 □ Donation 5 □ Other (Si	2			view Crema		1	07/2004		Baltimo	re, MD
Bal	pemit. F Departme Importan any Injur		21. Signature of Funeral Service	Licensee	1202	22.		ress of Facility		PA			
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			23a. Part1. Enter the disease, or shock, or heart failure. List-	complications that cau only one cause on eac	sed the dea th line.	ath. Do not ente	the mode of d	ying, such as c	ardiac or i	espiratory arres	it, .aa.	i	Approximate Interval Between Onset and Death
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	Examiner		disease or condition resulting in death)	a	The	1921JE 6	ble	corque	100	1000000	120	COL	
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n.	ritificate be executed ng physician end set the buriel-transit	Examiner	Cognecticity list conditions	P b		(or as a consequ		Ce Ce	/			1	
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68760,	ysicia ne bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to	(or as a consequ	ence of):						
89	ntifica ng ph es th	8	resulting in death) Last									i	
Вох	attendir		·	d									
	law requires thet the death certificate be executed the been signed by the attending physician end is 2 should be deteched for use es the bunel-transit	Physician/	Part II. Other significant condition	ns contributing to deat	h but not re	sulting in the und	derlying cause	given in Part I.		23b. Did tob	acco use con	tribute to	the cause of death?
P.O	d by t	<u>.</u>								1 □ Yea	2 □ No	3 ☐ Prob	ably 4 Unknown
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Ö	requi	Completed								24a. Was en performe		ava	re autopsy findings ilable prior to apletion of cause
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ō	S S D	<u> </u>	1 ☐ Yes 2 ☐ NO 27. Manner of Death	1 ∐ Inp		ER/Outpatient 28b. Time of	3LI DOA	4 Nurs		5 Residen d. Describe how)
on	ding the After fune	to l	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month,	Day Year)	Injury	28c. In W	ork? □Yes 2□N			,,		
Division	i or Attending after death. Director: After d in by the fune	108	3 ☐ Suicide 6 ☐ Could n	ot be 28e. Place of	Injury - At	home, farm, stre	et, factory, offic	e	28	Location (Stre		er or Rural	Route Number,
ă	after after Dire	Certification:	4 ☐ Homicide	building	, etc. (Spec	cify)				City or Town,	State)		
	noun nor y fill	edical	(Check only 2 Medical I	g Phyaician: To the be examiner: On the bas	s of examir	nowledge, death on ation and/or investigation	occurred at the estigation, in my	time, date and opinion, death	plece, and	d due to the cau	ise(s) and mai e and place, a	nner as sta	ated. the cause(s)
	To the Ho within 24 To the Fu completel	8	one)	and manne	r stated.			nse number					
	5 ½ 5 ½		29b. Signature and title of certifier	5 Dank			28G. LICE	D'3061	1.1	1	d. Date signed	- 6 5	2004
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	Ce		30. Name and address of person of RG MECH Saba				RIVE	Neck	Koa	d Ba	Himer	Mai	ylad 21221
	Stat Registra		31. Date filed (Month, Day, Year)	32. Reg	istrar's Sign	nature Ann	ch						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 5 Month **Physician** 11:00 2004 Durne11 August Ellen Virginia /Medical 4c. County of Death 4b. City. Town, or Location of Death 4e. Facility Name (If not institution, give street and number) Examiner Anne Arundel Mariner Health of Glen Burnie Glen Burnie ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) 4-11-1918 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** WEST VIRGINIA 1□M 2\ F Yrs. 86 234-03-8514 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director GLEN BURNIE ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1028 BELL AVENUE Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes XXNo Maryland 21215-0036 Specify: Specify: WHITE þ 3₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) Coflege (1-4or 5+) and Mentat Hygiene. **HEALTHCARE** NURSE, LPN 18. Mother's Name (First, Middle, Maiden Sumame) 17, Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked cony injury or other traumatic av-ETHEL LOU LEMON JAMES A. STEELE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MRS. SALLEE FITZSIMMONS-DAUGHTER 1289 AMMENDALE COURT, MILLERSVILLE, MD 21108 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/9/2004 GLEN BURNIE, MD GLEN HAVEN * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SINGLETON FUNERAL HOME P.A. 21. Signature of Juneral 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 MOHAD 236. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** tennos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) attending physician and for use as the burial-transit certificate be executed Khaumstocal Mark Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death detached for 5 Other (specify) P.O. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2 🔽 No or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Marsing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 VNo 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours a To the Funeral I Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only o the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, MB 816 D 4051 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Perk 6ten Busnie 21061, Marzano 1407 Madison m. NUSCires 31. Date filed (Month, Day, Year) AUG 1 0 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ÄÜĞ 6, Prakash Lal Grover 2004 7:26a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 2102 Pot Spring Road Timonium Baltimore 8. Date of Birth JUN 20, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** r1938 Months Days Hours 1**X** M 2□ F India 212-58-3488 66 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or Items 23a or 28a-f show 1 ☐ Yes 2 No Maryland Baltimore Timonium Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2102 Pot Spring Road USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Madical Examiner: 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Asian Indian 2 3 ☐ Widowed 4 ☐ Divorced "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Scientist U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental is marked o Charan Das Grover Krishna Wati 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Surat Kapoor Grover/wife 2102 Pot Spring Road Timonium, MD 21093 item 27 i other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page:
Department or
Important: If any injury or ö Metro Crematory, Inc. 8/7/04 ` 4 ☐ Donation Baltimore, MD 21. Signature of Funeral Funeral Service MM Dawn F MacNabb Funeral Home, P.A. 301 Frederick Road Baltimore, MD 21228 McDonald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FOLLICULAR SMALL CLEAVED CELL **Physician** YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 5 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 1 🗆 Yes 2 200 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 certificate or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ٩ 1 Yes 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number D 2 9 3 7 3 29d. Date signed (Month, Day, Year) 8/6/04 cause of death (Item 23a) (Type, Print) SUITE 200 LUTHERVILLE, MD 21093 ERIC J. SEIFTER, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. U Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:25 AM ivian /Medical Facility Name (If not institution, give street and number) 4c. County of Death n. or Location of Death **Examiner** Baltimore 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 1 F Months Days Hours Min Yrs. Director nce of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hyglene.
not: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show ant; If Item 27 is marked other than "naturel", or lieme 23a or 28a-f show any or other treumatic event. The Medical Expanding mutable notified at any or other treumatic event. The Medical Expanding mutable notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Completed by Funeral Director 1 Yes 2 1 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Capan, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No BIACK Specify: 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5 look Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Andress (Street and Number 20a. Method of Disposition - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important; If any injury or once. 10-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaudon C Greens Foreral b. Randallotown mo 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Priysician disease or condition resulting in death) Pars /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0 9 Unknown cete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Tyes 2 12 No Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2X No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 PNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No hours efter death. 2 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours of To the Funerel D 29a. Certifier 1 🔁 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37573 5,2004 cause of death (Item 23a) (Type, Print)

State Registrar

30. Name and address of person who complete

Zibell

AUG 1 0 2004

31. Date filed (Month, Day, Year)

MD

21136

Mais

32/Registrar's Signature

52

CPM 04-05125 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. LYNETTA GREEN State of Maryland / Department of Health and Mental Hygiene - State
Registrer #23a PTI 27 28a-f

1. Decedent's Name (First, Middle, Last) Certificate of Death RegiNo Unpend item 2. Date of Death **Physician** 11:37 A^M LYNETTA LASYN GREEN 2004 August 07, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Susquehanna River at Tydings Bridge Perryville Cecil If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ √F Director 205-58-3435 PENNSYLVANIA 01/26/1971 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Medical Examinar must be notified at 1 ▼Yes 2 No N/A Director PAPHILADELPHIA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1840 MERIBROOK ROAD Completed by Funeral USA 14. Race - American Indian, 19150 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after on and Mental Hygiene. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISPATCHER VERIZON 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERNARD GREEN JOSEPHINE GREEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE GREEN MOTHER 2953 N. BONSALL ST. PHILADELPHIA, PA Department of Health Importent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1. ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury PEACE CEMETERY 8/14/2004 PHILADELPHIA, PA 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON. MD 21286 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Drowning /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 9SH 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ło in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9X Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, **Bupropion Intoxication** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 □ es 2 □ No 24a. Was an page 2 autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) SCENE Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 Yes 2 No Found 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 Natural 5 Pending death. investigation 8/7/04 Subject drowned self 2 Accident 11:20 a Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Soecify) water 3X Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined after 4 Homicide Water

Water

Susquehama River

Cecil County

MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funerel (

State Registrar

To the

29a. Certifier

29b. Signature and title of certific

Medical

29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

August 08, 2004

Year

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kollak Mull11 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) AUG 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GRANVIlle Year Godwin Jesse 2004 6 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner rarkville BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) V. Caroling **Funeral** Days Min. Months Yrs. Director 10a State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If item 271s marked other than "natural", or Items 27a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ganes. Once. 10d. Inside City Limits 1 ☐ Yes 2 No Director PARKVILL PALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Blvd. #161 2123 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within and Mental Hygiene.
Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) rectworker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Immant's Name/Relationship (Type, Print) 8810 watthe BVd. # 1617 PARKING IF MD 21234

20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date -9-04 FOREST HILL, MAD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility FOREST HILL, MA 21050 unlier FUANS FUNGRALCHAPEL BELAIR. 3 NEW PORT DR 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** failure Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner JUCY D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury YEW Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à COPD 3 Probably 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No rmed 2 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death | Check on vone 1 🗌 Yes Other: ပ 2(5) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DJ3115

Registrar

State

walth

32. Registrar's Signature

Partable mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4400

rongenn

AUG 1 0 2004

31. Date filed (Month, Day, Year)

			For State Registrar	State of Marylar	•		of Health and of Death	d Mental Hy	giene Reg. No.) 4 /	25122
	Physicia	n	1. Decedent's Name (First, Middle, Last)	zabeth Susan	na Car	rdon		2. Date of De Month	aath Day	Year	3. Time of Death
	/Medica	al	4a. Facility Name (If not institution, give s		ina Goi		own, or Location of D	Aug.	3, 20 4c. County		12: 50 ₽
	Examine		Salisbury Nursing a		tor	40. City, 1	Salisbu		Wicom		
	Funeral		5 Social Security Number 6, Sex	7. Age (In vrs.		If Under 1	Year If Under 24				ace (State or Foreign
	Director		210.30.0433	M 2XF	83 Yrs.	Months	Days Hours N		v 6, 1921		Germany
	pue *	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation			, 0, 1021		Od. Inside City Limits
	f sho	ō	Maryland Balti	more			Catonsville				1 ☐ Yes 2 No
	r 28a	rec	10e. Street and Number	illore		10f. Zip C			10g. Citizen of	What Count	try?
	th with	a D	132 Nunnery Lane				2122	8		U.S.	A.
	72 hours after death with the Maryland neturel', or tems 23a or 28a-f show sical Examinat the most be redified at	Completed by Funeral Director	T. Marian States	Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decede f Yes, specif	ent of Hispanic Origin? by Cuban, Mexican, Po	(Specify Yes or No uerto Rican, etc.)	o- 14. Rad Bla	e - America ck, White, e	
36	rs afte	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No Specify:		Specif	y: 1	White
8	2 hour	edt	15. Decedent's Educ	ation	16a. Deced	dent's Usual	Occupation		16b. Kind of B		
215	within 72 ene. then "ne he Medi	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during most of retired)	working		at ho	•
21	e filed within al Hygiene. other then " vent, the Me	Con	12				homemaker				
pu	be fill ital Hy id oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle		,	
ordon Maryland 21215-0036	should and Men s marke umetic	၉	Frederic 19a. Informant's Name/Relationship (Typ	k Leser	10b Mailin	a Addrose /	Street and Number or		na Marie G		Cadal
Gordon e, Maryl	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumetic event. Its Medical Era minar must be notified at		Mr. Herman Lapole	Nephew			341 Upper Fa			State, Zip t	C00e)
ညှှ စုံ	of Hea		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name	e of	Date	20c. Location	City or Tov	wn, State
zabeth G Baltimore,	op 0		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	-	orial Park	08/07/2004	Ell	kridge, N	Maryland
abe	permit. Pag Department Important: I eny injury o once.	Ì	21. Simplure of Funeral Service License			. Name and	Address of Facility				
• 100	80599		Optimared and	L MOOS	3	38	lack Funeral Ho 371-Old Colum	bia Pike Ellico	ott City, MD	21043	
M	***		23a Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the dear e cause on each line.	th. Do not ent	er the mode	of dying, such as care A.	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	alghece	en	_	Juceon			Ge	107
· M	Examiner			Due to (or as a consec						1	0.41 .
1-10		Jer	Eaguer traily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):				- 0	1/4	aj-7.
P	icate be executed physician and s the burial-transit	Examlner	that initiated events	Chrone	olas	kine	Som	relach	n de	e -	jen-
90,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				1		1
8760	physic physic s the b	edlcal	đ								
9 X	eath certific attending pl	/We	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregn	ancy				23d Da	te of deliver	v
Вох	d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pre Other (spe					Day Year
P.O.	that the di	hys	9 Unknown	9□ Unknown							
	gne b ed	ру Р	Part II. Dther significant conditions con	tributing to death but not res	sulting in the u	nderlying car	use given in Part I.				e cause of death?
ord	w requir been si should	ted						- 10	Yes 2□No	3 ☐ Proba	ibly 4 Dianknown
ec	e taw i has be	Completed						24a. Was	an 24b.	Were autop	sy findings available pletion of cause of
<u>=</u>	icien: The t certificate ha ector, page							1 Yes		death?	2□No
Vit	ysicien: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	15D/0		Other	Death (Check only			
of	Phys or this aral di	Η,	27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of		c. Injury at Work?		dence 6 □Oth how injury occur		
ion	Attending Physicien: r death. ector: After this certifics by the funeral director,	atlor	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 □ Yes 2 □ No				
Division of Vital Records,	el or Attendi s after death. el Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str	eet, factory,	office	28f. Location (City or To	Street and Numb	er or Rural	Route Number,
Ō	itel or rs afte ref Dir	Cer		Juliania, sto. (open				G.I.J G. 10	, clarcy		
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier 1 — Certifying Phys (Check only one) 2 — Medical Examin	ician: To the best of my known: er: On the basis of examination and manner stated.	owledge, death ation and/or inv	n occurred at vestigation, i	t the time, date and pl n my opinion, death o	ace, and due to the ccurred at the time,	cause(s) and ma date and place,	inner as sta and due to t	ited. the cause(s)
	Withir To th Comp	Š	29b. Signature and title of certifier	0		29c.	License number	0	29d. Date signe	d (Month, D	lay, Year)
•			MULL	٦		5	12534	1	97/1	4.	
-			30. Name and address of person who con					/	- 1 - 7		
	10		31. Date filed (Month, Day, Year)	ins M.J.		346 S	. Division	St.Suite	.Sa isbu	ry, M	ld.21804
	Stat Registra		ANUG 1 Q 2004	ener &		els					

DHMH 17 Rev 1/2001

			_ For	State of Marylan	-			ental Hygi	ene	
			State Registrar	·	Cer	tificate of	Death		g. No. U U 4	25/23
	Physicia		1. Decedent's Name (First, Middle, La	35()	Ga	dd is	5	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, given	ve street and number)			r Location of Death		4c. County of Dear	-
			Franklin Square 5. Social Security Number 6.	Sex 7. Age (In yrs.	ter himbday	Rosed If Under 1 Year	ale If Under 24 Hrs.	8. Date of Birth	Baltin	hplace (State or Foreign
	Funeral Director			1□M 2×F 52	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	ountry)
	and W		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	72 hours after death with the Maryland natural; or itams 23a or 28e-f show Acal Examinat , use be notified at	tor	MO	R	oseo	dale				Yes 2□No
	or 28	Funeral Director	10e. Street and Number	1.		10f. Zip Code	2 ~	10	g. Citizen of What Co	untry?
	ns 23	erai	1420 PEPERA	12. Was Decedent Ever in U	.S. 13. V	Vas Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race - Ame	nican Indian,
98	or its	y Fur	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
00-	Phours	ed by	3 ☐ Widowed 4 1 Divorced 15. Decedent's 8	Education	16a. Deced	ent's Usual Occup	ation	1	6b. Kind of Business	Industry
215	ithin 72	Completed	(Specify only highest gr Elementary/Secondary, (0-12)	rade completed) College (1-4or 5+)	life. I	OO NOT use retired	during most of workii d)	ng	\sim 1	
325	filed within Hygiene. Ither than "	Co	17. Father's Name (First, Middle, Las	r)	Ca	shier	18. Mother's Name	/First Middle M	Reta	
eatrice Maryland 21215-0036	Mental Me	To Be	Raymond	Gaddis			•		ek son	
Mary	2 should and Men Is marke		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	Route Number,	City or Town, State, I	Zip Code)
e, C	1 and Health em 27 ther tr		(nante Hol		142 Place of Dispo	D PROPO sition (Name of		Rosed	ecle 21 0c. Location - City or	237
S mor	Pages nent of int: If it		Burial 2 Cremation 3 [4 Donation 5 Other (Speci	Removal from State	emetery, cren	natory or other place	7-9	1-04 1	Mud a	IKMD
addis Baltim	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itams 23a or 28e-1 show any injury or other traumatic event, it a Modeal Expulsive must be notified at once.		21. Signature of Funeral Service Lice			Name and Address	ss of Facility havistr	fH ,	ZU NYCA CA	71.0.
\$ ■	907 4 0		23a. Part 1. Enter the disease of con	nolications that caused he deat	h. Do not ente	confeas+	or N AV	e 134 lte	0. MD 21	Z 5 1 Approximate
Ă	Physician		23a. Part1. Enter the disease of conshock, or heart failure. Sist only Immediate Cause (Final disease or condition	C. 1.	Shoch	,,,,,	y ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
_	/Medical Examiner		resulting in death)	a. Due to (or as a conseq						
		er	Sequentially list conditions,	b. TIVER to	ilure					
	cuted nd ransit	Examiner	ary, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	с.						
8760,	ate be executed hysician and the burial-transit	icai Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
9	tificate ig phys as the			d						
Вох	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta	I death 3	Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
P.O. I	the deay y the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	eath 5∟	Other (specify)				July 10al
	uires that the de signed by the a id be detached f	by Pt	Part II. Other significant conditions	contributing to death but not res	ulting in the ur	iderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	/
ord	v requir been si should								3 2 No 3 Pr	
Division of Vital Records,	The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed						24a. Was an autopsy perform	ed2 prior to death?	stopsy findings available completion of cause of
/ital	ysician: Th is certiticate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of Death		ZNo 1 ☐ Yes	2 No
of \	Phys this ral dii	P.	1 ☐ Yes 2 ☑ No 27. Manner of Death		ER/Outpatien		4 Nursing Hor	ne 5 🗌 Resider 28d. Describe hov	nce 6 Other (Spe	oify)
ion	Attending Phyrdeath. ector: After thi	ation	1 ☑Natural 5 ☐ Pending investigated	28a. Date of Injury (Month, Day Year)	Injury	28c. Injun Worl M 1	k? Yes 2 □ No		,,	
ivis	or Atte	Certification;	3 Suicide 6 Could not l 4 Homicide determined		ome, farm, str	eet, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
_	To the Hospitel or Attenwithin 24 hours after deal To the Funeral Director: completely tilled in by the		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wiedge, death	occurred at the tin	ne, date and place, a	and due to the car	use(s) and manner as	stated.
	the Ho hin 24 th the Fu mpletely	Medical	(Check only 2 Medicel Exa	miner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	pinion, death occurre	ed at the time, dat	te and place, and due	to the cause(s)
	or or or or or or or or or or or or or o	<	29b. Signature and title of certifier	Surt D.O		Res		29	d. Date signed (Mont.)	(, Day, Year)
	12		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,	Print)	• •	.1:		
	- 01		Dr. Te ffery Suc	ett 9000 Fra	nthlin S	guare P	rive, Bo	altimore	e MD.21	237
	Sta Registr			104 Kingue L	4 Con	de				

DHMH 17 Rev 1/2001

Depocation from first, Making, Last of Ball Services of Death And The Country of Serv			•	State of Maryland / Department of Health and N 1 - State Registrar AMEND ITEM #20b PER PH C834 861916 Sept. Department of Health and N		iene	25 24
Examination Exami		0			2. Date of Deat	th	3. Time of Death
## Sets from a circumstance of positions and productions of the control of the co				Clara Harper	73		1:45 PM
Display of the Market of Display of the Country of the Market of Displa				4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1
Display of the Market of Display of the Country of the Market of Displa				Union Memorial Hospital Baltimore	e	NIA	
This State was a service of the order of the					8. Date of Birth	Year) 7 A Birth	place (State or Foreign intry)
The State of the property of t	ŀ	Director		212-24-0228	110V.6,	172/11/6	arylana
The process of the pr		land ow					10d. Inside City Limits
The process of the pr		Man -f sh	to	Maryland NIA Baltimore			1°SYes 2□No
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The process of the pr		th will	aiD	3937 Greenmount Ave, 21218		usi-	1
The process of the pr		r dea	ne	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		
The process of the pr	36	s afte		ITYES GIVE?		Specify: 1	L
The filter's Name (Fraz, Middle, Lau) 1. Submitter Name (Fraz, Middle, Lau) 1. Submitter Name (Fraz, Middle, Middle Cana) 1. Submitter Name (Fraz, Middle, Middle C	Ş	turel	ed b			16b. Kind of Business/li	ac L
The filter's Name (Fraz, Middle, Lau) 1. Submitter Name (Fraz, Middle, Lau) 1. Submitter Name (Fraz, Middle, Middle Cana) 1. Submitter Name (Fraz, Middle, Middle C	212	nin 72 Bri ni	plet	(Specify only highest grade completed) (Give kind of work done during most of work	king		· - · · ·
The state of the s	2	d with giene ar tha	mo:	School Teacher		Board of	Education
The state of the s	g	al Hy al Oth d oth		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, I	Maiden Sumame)	
MS_TUNE TOOMSON Printing field Ave. Batto. Mass 20 about	<u>yla</u>	Ment Ment arked arked		Eugene Mompson Gold	lie	Utter	
20. Place of Deposition (August of Depositio	ā	2 short and reum		11 T T T	ral Route Number	r, City or Town, State, Zi	ip Code)
2.3. Spriftle of the respective of the control of t		1 and Health am 27 ther t		20a Method of Disposition 20b, Place of Disposition (Warre of	HUE, E	20c Location - City or T	Town State
Physician Medical Examiner Examiner	ğ	nt of i		1 Dutial 2 th Clemation 3 memoral noni state 1/1		Rall- A	1 A
Physician Medical Examiner Examiner		artme orteni injury	ı	Cietti betii Ciencii	-104 drift	Dalto, I	<u>aa.</u>
Physician (Medical Examiner) Part Commence Comme	Ba	Dep Imp			tuner	al Home	51316
Physician Medical Examiner Physician Medical Examiner Physician Medic				23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate
Due to (or as a consequence of) Security	Physician						
Due to (or as a consequence of): Control of the part of the par		/Medical		resulting in death)			Tuay
The proposed of the property o	п	Examiner		Sequentially list conditions.			
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State		and and Il-tran	хап	that initiated events c.			
FFEMALE 236. Mas decedent pregnant in past 12 mynths? 1 leve size 12 mynths? 1 leve size 2 months 2 leve of death 2 leve of de	9	sician buria					
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	89	ificate g phy as the	edic	0.			
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1	ŏ	n cert endin use	M/M	23h. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli-	very
1 Yes 2 24a. Was an autopsy findings available prior to completion of cause of death? 24a. Was an autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death? 26. Place of Death (Check only one) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury of Work? 28a. Date of Injury of Month, Day Year) 28b. Place of Injury of Month, Day Year) 28c. Injury of Work? 28d. Describe how injury occurred 28d. Describe how injury occurr			slcie	1 Yes 2 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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Amend item #5 per FH C835, 9/8/04 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item #23a, 27 per ME C834, 8/2//04 TT
State of Maryland / Department of Health and Mental Hygiene MARY HATCH 04 - 5081dap Amend item Registrar 26 per ME, G834, 8/27/04 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year /Medical AUGUST 2004 1:40p4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 310 SOUTH SPRING COURT BALTIMORE CITY 5. S**214064+531**1 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9 Birthplace (State or Foreign 1 ☐ M 2 💢 F Months Days Hours Yrs. Director filed within 72 hours after death with the Maryland 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be ustilled at Be Completed by Funeral Director 1 Yes 2 No Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a 0 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 20 No Specify Blac Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ome d 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be enjami 19a. Informant's Hame/Relationship (Type, Print) (mother) 19b. Mailing Address (Street and Number or Rural Route Number, City Wyano alto.11/a.2/21 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) arme 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph 2222 W. North Ave. 23a. Parl 1 Enter the dis shock, or heart fail Immediate Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pnysician Complications of Chronic Alcoholism disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Be Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Yes 2 No 2 🗆 No Yes To tha Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 12 Residence XXOther (Specify) Scene 15 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCME** AUGUST 6, 2004 me and address of person who completed cause of death (Item 23a) (Type, Print) MO111 Penn Street, Baltimore, Maryland 21201 TOLLAK 32. Agistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 5, Day 2004 Year **Physician** 11:32pM William George Hupfeldt, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, AUG 23 Birthplace (State or Foreign Country) **Funeral** Days Y01960 1 XM 2□ F Hours Maryland 213-50-4553 43 Vre Director Usual Residence of Decedent 72 hours after death with the Maryland 10b Count 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Maryland Baltimore Director Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 11321 Glen Arm Road 21057 USA or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. t ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William George Hupfeldt Nancy Kidder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If itam 27 is any injury or other trau Katherine G. Hupfeldt/wife 11321 Glen Arm Road Glen Arm, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/6/04 ^¹ 4 □ Donation Baltimore, MD Dawn F. Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 McDonald 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Amyonophic Due to (yr as a consoluence of): Immediate Cause (Final Physician Geals disease or condition resulting in death) /Medical Examiner Sequentially list conditions, Due to for as a consuluence of Examiner cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence ther (Specify) Hospital: 1 ☐ Yes 2 № No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: tha Hospital or Attanding 5 Pending Natural within 24 hours after death. To the Funeral Diractor: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

tupfeldt, William

MISSAPM

5,2004

Registrar

DHMH 17 Rev 1/2001

AMON S. Charles 31. Date filed (Month, Day, Year)

29b. Signature and fille of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier (Check only one)

29c. License number

harles

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			1 For State	State of Marylar	nd / Depa		alth and Me	ental Hygie	ene	0:110
			Registrar 1. Decedent's Name (First, Middle, L	astl	Cei	unicate of D		Reg 2. Date of Death	. No.	3. Time of Death
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	Francis		Brightwood Nu: 5. Social Security Number 6.	rsing Center Sex 7. Age (In yrs.	last hirthday)	Luthery If Under 1 Year		8 Date of Birth	Balti	
	Funeral Director			1₩ 2□F 86	Yrs.		Hours Min.	8. Date of Birth (Month, Day, Y Jan.5,	1918 Ma:	thplace (State or Foreign ountry) ryland
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	with t	Dir	10e. Street and Number 3000 Towanda A	Avenue #213		10f. Zip Code 21 21 5			. Citizen of What C	ountry?
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900	urs after al', or ite Examina	To Be Completed by Funeral Directo	1 Never Married X2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Mexican, Puerto R Specify:	lican, etc.)	Specify: B	
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Ma	nd 2 s lith an 27 is i		Fannie Holden/		3000	g Address <i>(Str</i> eet and Towanda	Avenue A	pt. 213	Sity or Town, State, .	Zip Code)
Č,	of Heal		20a. Method of Disposition	20b. P		sition (Name of natory or other place)	Da	te 200	c. Location - City or	
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Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Funeral Service Lice	ansee Auruja	52·	Name and Address of 40 Reiste	^{of Facility} Chat erstown	tman-Ha Rd Bal	rris Fu	neral Home Md 21215
			23a. Pert 1. Enter the disease, or conshock or heert failure. List only	inplications that caused the deeth	n. Do not ente	er the mode of dying, s	such as cardiac or	respiratory arrest	,	Approximate Interval Between
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	Examiner			Due to (or as a consequence of the Consequence of t	uence of):					MONTHS
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687			`	d						
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □Live birth 2 □ Fetel 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
٦.	igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but not resu	ulting in the un	derlying cause given i	n Part I.	23e. Did tobac	co use contribute to	the cause of death?
of Vital Records,	w requires been sig should be							1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Dunknown
ဝင္ပ	e law re has bea je 2 sho	Completed						24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
<u>~</u>	cate ha	Con						performed	? death?	2☐ No
₹	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		04	6. Place of Death (-
ō	ding Phys h. After this funeral di	2	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injury at		5 Residence d. Describe how i	e 6 □Other (Spec	cify)
<u>o</u>	ttending death. ctor: Afte y the fun	atio	↑ Natural 5 Pending 2 Accident investigation	(Month, Day Year) in	Injury	Work? M 1 ☐ Yes	2 □ No		,,	
Division	Hospitel or Attending 24 hours after death. Funerel Diractor: After tely filled in by the fune	Certification;	3 Suicide 6 Could not be determined		me, farm, stre	et, factory, office	28	f. Location (Street City or Town, St	t and Number or Ru tate)	iral Route Number,
	To the Hospitel or Atten within 24 hours after deat To the Funerel Diractor: completely filled in by the	Medicai C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time, estigation, in my opinio	date and place, and on, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License nu	ımber	29d.	Date signed (Month	n, Day, Year)
	{		5	abte MD		D00.	53150	JL	143155	2004
	K		30. Name and address of person who	completed cause of death (Item	23a) (Type, F	Print) D POB	30× 630	3 EC	ULOTT	(174
8	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signar	ure /	./ ,				1 40 HO A 5
	Registr	ar	AUG 1 0 2004	Street 10	10	auxs/				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 4:12 AUGUST 2004 echNer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Maryland Medical Center ltimore University of If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 13, 1 Birthplace (State or Foreign Country)
 MD 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🕅 F Yrs. 84 Director 220-01-2150 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or Itams 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Mudical Examiner must be notified at 1 ☐ Yes 2X No MD Frederick Mount Airy Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2615 Gilbert Road 21771 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bookkeeper Furniture Store other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Wilson Wellham Ida Virginia Shipley ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilbert Road, 2615 Mount Airy, MD Carole J. Burl / daughter 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 6 permit. Page Department of Important: If Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Mark ll. MO1357 1 Second Ave. SW, Glen Burnie, MD 23a. Part 1. En ... he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sided **Physician** 4hT disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to min surate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as the t 150 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Dav 5 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 1 Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Diractor: / 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21046 Brook Drive Apt 72 7356 Eden MD Nolar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 0 2004 Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	f Marylan		artmen tificate			and M	-	giene Reg. No.	04	25129
	Physici	an	1. Decedent's Name (First, Middle, La	ist)							2. Date of De	ath Day	Year	3. Time of Death
	/Medi		Velma -	LSOM							AUGUS	ST 04 2	.004	2:00 pm M
4	Examir	ner	4a. Facility Name (If not institution, give		nber)				Location o	of Death			nty of Death	
			HARBOR HOSP 5. Social Security Number 6.5		7. Age (In yrs.	last hirthday)	If Under	ALTI	MORE If Under	24 Hrs	9 Data of Bi-		N/A	-1 (0)
	Funeral Director		224-54 - 8694	1 M 2 F	62	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da 3-06-1	949'	Vir	place (State or Foreign ntry) ginia
			Usual Residence of Decedent								3 00 1	. 7 14	, 11	511114
	ylan how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	a-fe	ctor	Maryland n/a		Ba1	timore								1 Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen d	of What Cou	ntry?
	ath w	rall	2409 Brohawn Ave	7			212					Unite	d Stat	tes
	er deg	une	11. Marital Status	Armed For	dent Ever in U.	.S. 13. \	Nas Deced f Yes, spec	lent of Hi	spanic Ori n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.))- 14. R B	ace - Amen lack, White,	
36	or l	γΕ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv	2 No 8		1 ☐ Yes	No	Specify:			Spec	cify:	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f ehow he Medical Ever in er must be revitified at	Completed by	15. Decedent's E	Year or Da	ites:	16a Decer	iont's Heur	I Cooun	ation			16b. Kind of		ite
15	in 72	olet	(Specify only highest gr	ade completed)		16a. Deced (Give life. I	kind of wor	rk done c se retired	during mos	of worki	ing	TOD. KING DI	Dusiness/ii	loustry
212	1 with jene.	mo	Elementary/Secondary (0-12) 8 years	College (1	-4or 5+)	Homem						Own H	ome	
	illed Hygie other	0	17. Father's Name (First, Middle, Last	")					18. Mothe	r's Name	(First, Middle	, Maiden Sum	ame)	
<u>a</u>	ould be Mental arked o	To B	Lil Oscar Sturgi	11					В	essi	e Maybe	erry		
Maryland	2 should and Men is marke eumatic	ļ -	19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	g Address	(Street a	ind Numbe	r or Rura	al Route Numb	er, City or Tow	m, State, Zij	o Code)
	and 2 palith n 27 i		Granville Sturgil	1 (Brot						Bal	timore,	Mary1	and 2	21224
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3 □	Removal from 9	20b. P	Place of Dispo emetery, crer	sition (Nan natory or o	ne of ther place	9)		Date	20c. Location		
Ĕ	Pages ment of ent: If it ury or o		• 4 Donation 5 □ Other (Speci		Pow				,		0-2004	Big Sto Virgin	one Ga ia	1 p,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any injury or other treumatic event. The Mudical Euro, incr must be notified at once.		21. Signature of Funeral Service Lice			Mc	Cully	d Addres	s of Facilit	k Fu	neral H	lome. P	. A .	
	Ø □ = e Ø			mo		- 23	7 E.	Pata	psco	Ave	<u>. Balti</u>	more,	Maryla	and 21225
				plications that co	aused the deatr ach line.								4	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Co. se (Final disease or condition resulting in death)	a	Ather	seles	61.6	11	sel	OVEN	culos	11-se	all	
	Examiner		1	Due to (or as a consequ	uence of):	~							
		آة.	Sequentially list conditions,	b. — Due to [or as a cons	uence of	110	11,1	1					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
oʻ.	exec an an	Exa	resulting in death) Last	c. Due to (or as a consequ	uence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cal		_ d										
Õ	death certifica attending ph	Physician/Medical	JF FEMALE:											
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregna		Ectopic pr	egnancy				1	Date of deliv	,
	e dea the at	sici	1 Yes 2 ANO	4□Pregn. 9□Unkna	ant at time of de	eath 5	Other (sp	ecify)				,	Month	Day Year
P.0	res that the de signed by the a be detached f	Phy	Part II. Other significant conditions	contributing to de	ath but not resi	ulting in the w	ndorh/ing o	ausa awa	o in Part I		23a Did t	obacco use co	entribute to t	he cause of death?
Records,	signe d be d	d by	11. 0-2-1-05	WO CL	attribut not ros	aking in the di	idonying o	ause give	ni ili i con i.			Yes 2□No		
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<u>a</u>	ding Physicien: The n. After this certificate hi funeral director, page		25. Was case referred to medical	1				0			1 Tes	2-1No	1 🗆 Yes	3 12 4 0
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ion	ttending F death. ctor: After / the funera	atlo	1 Natural 5 Pending 2 Accident investigation		n, Day rear)	Injury	М		? /es 2 🗆 l	No				
Division	200	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place	of Injury - At ho	ome, farm, str	eet, factory	, office		1	28f. Location (S City or Tox	Street and Nur.	nber or Rura	al Route Number,
	itel or A irs after rel Directed in by	Cer		_ 4						1				
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Exa	miner: On the ba	sis of examinat	wledge, death tion and/or inv	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due to	stated. o the cause(s)
	thin 2 thin 2 the ample	Med	29b. Signature and title of certifier	and mann	er stated.		29c	. License	number			29d. Date sign	ned (Month.	Day, Year)
	6 H E H		1011						328	2 1		8	17/20	/
7	2		30. Name and address of person who	completed cause	9 of death (Item	23a) (Type						0/	4/0-/	
			Christonher	Tol	no li	14/7 5	JUSL.	4	42/1	J. S	Yret	150/1	nn	21230
	Sta	ate	31. Date filed (Month, Day, Year) AUG 1 0 200	32,A	egistrar's Signa	ture	1							
	Regist	rar	AUG I U 200	4	never	4	An	100	,					

Baltimore, Maryland 21215-0036

Phys /Me Exar

Funer Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svent, It is Wedical Evaniner must be notified at

Pnysicia /Medic Examin

1 - For State Registrar AMEND I		of Maryland R FH G834	•					Reg. Ng	5 (5) (6)	1.	25126
Decedent's Name (First, Middle)		. 11 003	0417	O I OH			2. Date of D		- U U	1	3. Time of Deat
Louis	C.		Jira				Month August	6 .	^y 2004	Year	3:20 p
1a. Facility Name (If not institution		umber)	JIIa	4b. City, Town,	or Location	of Death	nagase		. County	of Death	
Stella Maris				Timon	i um				Balt:	imor	e
5-Social Security-Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Yea		r 24 Hrs.	8. Date of B	irth		9. Birth	place (State or Fore
213-30-0542 213-30-0547	1 ∑ M 2□F	72	Yrs.	Months Days	s Hours	Min.	(Month, D Sept	ay, Year)		Cou	ryland
Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside City Lin
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	timore		Balı	timore			-				
10e. Street and Number				10f. Zip Code				10g. Ci	tizen of W	Vhat Cou	intry?
602 Windwood Re	oad				21212	2			US	A	
11. Marital Status	12. Was Dec Armed F	cedent Ever in U.S.	13.	Was Decedent of If Yes, specify Cu	Hispanic Or	rigin? (Spe	ecify Yes or N	0-		e - Ameri k, White	ican Indian,
1 Never Married 2 Marr	ied 1 X Yes	2 □ No ive	-	1 ☐ Yes 2 🕱 No							, 516.
3 ☐ Widowed 4 X Divorced	If Yes, G Year or	Dates:		i∟ res 2LXIN	o Specify				Specify	W	hite
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(Specify only highes Elementary/Secondary (0-12)	Ţ-	(1-4or 5+)	life.	kind of work don DO NOT use retir	e during mo: red)	St OF WORK	ng				
12	College	5+	Lawy	yer				Rea	1 Es	tate	Law
7. Father's Name (First, Middle,	Last)				18. Moth	er's Name	e (First, Middle	1			
ouis J.		Jira			-	There	C 2		D 01	back	
19a. Informant's Name/Relations		JIIa		ng Address (Stree				0:			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Ce

29a. Certifier

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR • TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

AUG 1 0 2004

29b. Signature and title of certifier

2300 DULANEY VALLEY RD.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D43725

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

south

Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Willis Williams Johnson 29 July 2004 9:20 ₺ /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 3713 Park Heights Ave Baltimore n/a If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral ★** M 2□F 214-50-6258 Director 56 3. 1947 S. Carolina Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-1 ehov any injury or other treumatic event, the Medical Examinar must be rigitled at 1 Yes 2 □ No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3713 Park Heights Ave 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. Yes 2 □ No If Yes, Give Vi 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married ★ Married Viet Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify:Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates Nam Era Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Lazzitty Construct-Elementary/Secondary (0-12) College (1-4or 5+) Pipe Layer 12th grade ion Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willis Johnson Bernice Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Byrd/ Mother 3713 Park Heights Ave Baltimore, Md 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/6/04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service License 5240 Reisterstown Rd Baltimore. leay Md21215 Muria 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mod-shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death f dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): ed by the ettending physicien detached for use es the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 director, page 2 should be 2 🗆 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending 1 Natural efter death. 2 🗌 No 1 Tes 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) Type, Print) Day, Year 2004 31. Date filed (Month, 32. Registrar's Signature Year) State 0 AUG 1 Registrar

State of Maryland / Department of Health and Mental Hygiene

		State of Marylan	Certificate of Death	Rea. No. O O I O I I O O
		1. Decedent's Name (First, Middle, Last)	2.	Date of Deeth
н	Physician /Medical	Baba Boy Jackson		Month Dey Year 10:31 fm
	Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Locati	
		Mercy Medical Center		ore City N/A
	Funeral Director	5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs.	/est birthdey) If Under 1 Year If Under 24 Hrs. 8. Months Deys Hours Min. S. Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. 2.3. 204 M. M. M. M. M. M. M. M. M. M. M. M. M. M	
	pue *	Usuel Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location	10d. Inside City Limits
	laryle eho			1⊠Yes 2□No
	or 28a-fe be notified Director	MD N/A 10e. Street end Number	Baltimore 10f. Zip Code	10g. Citizen of What Country?
	with po a D	100 1117		3 2 2 1 2 2 1
	r items 23 where must	301 McMechen St APT 1117 11. Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici	Yes or No- 14. Race - American Indian,
(0	r Rer dreg	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No		an, etc.) Black, White, etc.
21215-0036	Darmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show moortant: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other traumatic event, the Medical Examiner must be notified at ance. To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: Black
2-0	ed within 72 hours that the mature it, the Medical E.	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business/Industry
21	and and and and and and and and and and	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
	Hygiene. ther ther	Infant	Infant	Infant
nd	d oth	17. Father's Neme (First, Middle, Last)	18. Mother's Name (Fi	rst, Middle, Maiden Surname)
yla	should be and Mentel marked o umartic eve	Unknown	Lakisha C	
Maryland	2 sho	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Re	oute Number, City or Town, State, Zip Code)
	and leelth m 27 her tr	Lakisha Jackson/Mother	301 McMechen St. Apt 111	
0	t of H If ite or ot	20a. Method of Disposition 1 🔯 Burial 2 🗆 Cremation 3 🗔 Removal from State	emetery, crematory or other place)	20c. Location - City or Town, State
E E	tmen tent: fury			.0/04 Baltimore, MD
Baltimore,	parmit. Pag Depertment Important: I eny injury o	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Sterling Ashton Schwa	ab Funeral Home, Inc.
_	20.5 • 0	Edward H. Lenkuns	736 Edmondson Ave. Ba	altimore, MD 21228
		23a. Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac or re	spiratory arrest, Approximate Interval Between
	Physician	F- 1	()	Onset and Death
4	/Medical Examiner	Immediate Cause (Final disease or condition	me prematurity	
н	100	resulting in death) e. Due to (o	r es a consequence of):	
	sit sit	b. Premi	uture rupture of m	embranes 3 wests
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for usa as the burial-transit completed by Physician/Medical Examiner	Sequentially list conditions, if env. leading to immediate	r as e consequence of):	1 1
9	ba e icien buria	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760,	phys s the	that initiated events Due to (or resulting in death) Last	as a consequence of):	!
Вох	certification of the same as a same a same as a same as a same a same a same a same a same a sam	d		
ă	attandin d for usa	Part II Other classificant and disland contribution to doubt but not require	thing in the underlying source sizes in fleet	22h Did tahasa una contributa ta the course of death?
P.O.	by the a	Part II. Other eignificant conditions contributing to death but not resu	uning in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
	signed to detect by Pl			TE 165 22760 SEPTOMENTY VESTICANI
rds	n sig			24a. Wes an autopsy 24b. Were autopsy findings
8	w requires been si should should			performed? available prior to completion of cause of death?
Re	The law requir sete has been s paga 2 should Completed			1 Yes 2 No 1 Yes 2 No
Vital Records,		25. Was case referred to medical	26. Place of Death (C	
	P 10 75	examiner?	Othor	5 ☐ Residence 6 ☐ Other (Specify)
10	g Phy er this eral c	27. Manner of Deeth 28a. Date of Injury		Describe how injury occurred
Ö	Attending or deeth. Sctor: After by the fune	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	M 1 Yes 2 No	
Division	Attender description by the	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify		Location (Street and Number or Rurel Route Number, City or Town, State)
	ai or Attending P rs efter deeth. ei Director: After t led in by tha funara Certification:	Building, etc. (Specify		ony or rown, orally
	bour bour by fills	29a. Certifier 1 Certifying Physician: To the best of my know	wledge, death occurred at the time, date and place, and ion end/or investigation, in my opinion, death occurred a	due to the cause(s) and manner as stated.
	To the Hospital or Attending Phy within 24 bhours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	one) and manner stated.		t the time, date and place, and due to the cause(s)
	To the to the total	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		It was the	1 246 646	Myst 5, 204
7		30. Name end eddress of person who completed cause of death (Item	23a) (Type, Print)	1121 By 1 Lange 40
		Dr lara Detamplet 3	OI STRAULTE ST	- 74 Daltimore/W
	State	31. Dete filed (Month, Day, Year) 32. Registrer's Signal	ture	
	Registrar	AUG 1 0 2004	ficarle	
DHI	MH 16 Rev 6/95	,	ORIGINAL	

			1 - For State Registrar	State of Man		artment of			2001	25133
	_		Registrar Decedent's Name (First, Middle, Las	:t)		timodio or	Dod.iii	2. Date of Death		3. Time of Death
п	Physici		Lillian May Kraf	t				Month August	4, 2004 Year	4:45 P M
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Death		4c. County of Deat	
			1700 Park Avenue				lethorpe		Ba	ltimore
	Funeral		Social Security Number 6. Security Number	- MA	n yrs. last birthday)	If Under 1 Year Months Days		(Month, Day,	Year) 9. Birth	nplace (State or Foreign
	Director		219-28-3711 Usual Residence of Decedent	IN SMIL	73 Yrs.			Jul. 9,	1931 Wash:	ington DC
	land		10a. State 10b. County	10	C. City, Town or Lo	cation				10d. Inside City Limits
	Mary 18h	ţo	MD Bal	timore		Haleth	orne			1 ☐ Yes 2 X No
	r 28a	irec	10e. Street and Number	CIMOIC 1		10f. Zip Code	.0190	10	g. Citizen of What Co	untry?
	th with	Funeral Director	1700 Park Avenue			2	21227		United Sta	ates
	ems ems	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
36	s afte	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 X No			Specify: Wh:	
8	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show Jical Examinium rust be notified at		15. Decedent's Ed	Year or Dates:	16a Decer	fent's Usual Occu	ination		6b. Kind of Business/l	ndustry
5	n "na	Completed	(Specify only highest gra	de completed)	(Give	kind of work done DO NOT use retire	during most of wor	king	ob. King of business/	idustry
212	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	er		Own Home	9
pu	al Hy I othe Vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	laiden Sumame)	
yla	Ment Ment arkec	70	Unknown Conno	rs	<u> </u>		Sara	h Lamati	no	
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (7	Гурө, Print)		_			City or Town, State, Z	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Mudical Examination is be notified at once.		Cheryle Massey 20a. Method of Disposition	Daughter	16689 20b. Place of Dispo		ntz Rd.,		7ille, MD 2	
Baltimore,	ages nt of I t: Mite	1	1 X8urial 2 ☐ Cremation 3 ☐	Removal from State	nd Wetera	hisy ceimet		-		
Ē	artme artme ortani Injury	(Donation 5 Other (Specify	11.0	at Crowns				Crownsville neral Home,	
Ba	Depa Impo any Ir	1	Callelin ! !	NOW					outus, MD 2	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not ent	er the mode of dy	ing, such as cardiac	or spiratory arre	st,	Approximate Interval Between
	Physician	W 1	Immediate Cause (Final disease or condition	Carar	2 Mish	unto	Mos	7		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	on equence of.	100				
н	Lamine	L	Sequentially list conditions, if any, leading to immediate	b. Due to (or v a co	renew	cog				
	pet light	nine	Cause (Disease or injury	Due to (or y a co	onsequence of):					
	execunand and al-tra	Examine	that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):					
8760,	ate be executed obysician and the burial-transit	cail	(d						
9	rtifical ng phy as th		IE EE MALE.							
Вох	death certifica e attending plad for use as t	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnanc	су		23d. Date of deliv Month	•
0	ie dea the at hed fo	Physician/Med	1 Yes 2 No	4∏Pregnant at time 9☐ Unknown	e of death 5□	Other (specify) _			Month	Day Year
<u>α</u>	that the de ted by the a detached t	Phy	Part II. Other significant conditions co	ontributing to death but no	ot resulting in the ur	nderlving cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	g be	d by		3	J	, ,,				bably 4 □Unknown
200	w requir been si should	lete						24a. Was an	24b. Were aut	opsy findings available
Re	he la e has age 2	Completed						autopsy	prior to co	empletion of cause of
Vital	an:] tificat tor, p	a	25. Was case referred to medical				26. Place of Dea	1 Yes 24		2□ No
	Physician: r this certificatal director, a	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3□ DOA Ot	her: 4 Nursing H	ome 5 Residen	ce 6 Other (Speci	fy)
n of	ding Physician: The lav h. After this certificate has funeral director, page 2		27. Manner of Death 1. DMatural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Inju	ry at	28d. Describe how	injury occurred	
sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	201 1 1: (2)		
Division	可能	Certification:	4 Homicido determined	28e. Place of Injury - building, etc. (S	At home, farm, stri Specify)	eet, factory, office		City or Town,	et and Number or Rur State)	al Houte Number,
	spital		29a. Certifier	/sician: To the best of m	y knowledge, death	occurred at the t	ime, date and place,	and due to the cau	se(s) and manner as s	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examone)	iner: On the basis of exa and manner stated.	amination and/or inv	estigation, in my	opinion, death occur	red at the time, dat	e and place, and due t	o the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifie	MILL		29c. Licen	se number	290	d. Date signed (Month,	Day, Year)
)	7) I find			0	04911		8/6/04	
	9		30. Name and address of person who o	completed cause of death	(Item 23a) (Type,	Print)	211000 0 1.36	KLTIL AIII	BALT!	פר בוב הנו
	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's		1	MANON I OF C	- (7 / V	- , Carli	MUXILLO
46	Registr		AUG 1 0 2004	Brown B	A CONTRACTOR					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 2004 ear **Physician** AUĞÜST 1:19A M HERBERT KOENIGSBERG /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE PIKESVILLE 3416 ENGLEMEADE ROAD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth MARCH 1, 1939 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Days Hours 65 MD 220-36-2503 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I've Medical Examinar must be notified at 1 Yes 2 No Director PIKESVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21208 U.S.A. 3416 ENGLEMEADE ROAD death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I ftem 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 5+ ORTHODONTIST DENTISTRY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KOENIGSBERG MARKS ANITA DAVID 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3416 ENGLEMEADE ROAD - PIKESVILLE, MD 21208 MARSHA KOENIGSBERG / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PK 8/9/2004 RANDALLSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage IV Non- Small Cell Lung 15 months **Physician** disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4. Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 2 ZNO 1 Yes Yes Division of Vital Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) To the Funeral Director: After the completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ō To the Hospitel o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my salaion, death 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 104 D0056919 Uncolog B (Item 23a) (Type, Print) 205 West 31. Date filed (Month, D. AUG 1 Day, Year) 0 2004 2. Registrar's Signature State Registrar

			1 - For Stata Registrar	State of Maryland		artment of H		•	giene	04	25135		
	Physici		1. Decedent's Name (First, Middle, Las JoHN	MYERS				2. Date of Dea	Day	2004	3. Time of Death		
	/Medio Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. Co	unty of Death			
	Funeral Director		Howard County Gen 5. Social Security Number 218-22-7240 Usual Residence of Decedent		ast birthday) Yrs.	Columbia If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6/28/1	HOW b, Year) 927	9. Birthp	place (State or Foreign ntry) yland		
	the Maryland r286-f show	rector	10a. State 10b. County Maryland Carolin 10b. Street and Number		, Town or Lo nton	cation			10g. Citizer	1 of What Cour	0d. Inside City Limits 1 ☐ Yes 2 No		
336	J within 72 hours after death with the Maryland jiene. r then "naturel", or llems 23a or 28e-f show the Medical Examinat must be inclified at	by Funeral Director	8202 Circle Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 (☑Yes 2 □ No If Yes, Give Year or Dates: WW ☐		21629 Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto Specify:	pecify Yes or No-		Race - Americ Black, White, ecify:			
21215-0036	within 72 hou ene. then "nature he Medical E	Completed	15. Decedent's Graci (Specify only highest graci Elementary/Secondary (0-12)	ucation	16a. Deced (Give life. L	lent's Usual Occupa kind of work done of OO NOT use retired,	uring most of work	king		of Business/Ind			
Maryland 2	be filed Ital Hyg od othe event,	To Be Co	8 17. Father's Name (First, Middle, Last) John Herbert	Myers, Sr.	Owner	/ Operat	or 18. Mother's Nam Alberta			trical			
Mar	nd 2 s lith an 27 is r treu	J. 33	19a. Informant's Name/Relationship (T Anna Myers (Wife		1	g Address (Street a		ra <i>l Route Numbe</i> nton, Ma	_				
nore,	Pages 1 and nent of Healt int: If item 2 iry or other		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	metery, cren	sition (Name of natory or other place	8,	Date / 1 0	20c. Locati	ion - City or To	own, State		
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	1101	22 B1	ll Mem. G Name and Addres Cuzdzinsk 407 Old E	-	l Home F	PA	Caracana A. A.	Maryland and 21221		
	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death ne cause on each line. a. Due to (or as a consequence)		e hear	t fai	live	rest,		Approximate Interval Between Onset and Death		
68760,	ate be executed ysician and he burial-transit	nysician/Medical Examiner	Examin	ical Examin	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		104 P	neumi	0015			4 av 1C/s
P.O. Box 68	death certifica e attending ph id for use as t				IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1	death 3 □	Ectopic pregnancy Other (specify)			23d.	. Date of delive Month	ory Day Year
	quires that in signed b uld be deta	þ	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the ur	nderlying cause give	n in Part I.		bacco use d es 2□N		ne cause of death? ably 4X Unknown		
al Records,	i: The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was a autop perfor 1 Yes	sy	prior to cor death?	psy findings available impletion of cause of		
of Vital	Physicien: T this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:	ER/Outpatien	Othe	26. Place of Deat			10.1			
ion of	fe and	-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury Work	- Indising ric	ome 5 Resid 28d. Describe h			9		
Division	- 9	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (City or Total)						umber or Rura	l Route Number,		
	To the Hospital o within 24 hours aft To the Funeral D completely filled in	licai	(Check only 2 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	ion and/or inv	estigation, in my op	inion, death occur	red at the time, o	late and pla	ce, and due to	the cause(s)		
)	Tot with	Z	29b. Signature and title of certifier 30. Name and address of person who ce Ramesh Sabapa 31. Date filed (Month, Day, Year) AUG 1 0 2004	Jun		29c. License	number 3064/	,	AUS	gned (Month, L unt 7	2004		
	107		30. Name and address of person who co	ompleted cause of death (Item	23a) (Tyge, I	CKKIVE	r Neck	Road	Ba	hmp	- Okcupant		
	Sta Registi	ite ar	31. Date filed (Month, Day, Year) AUG 1 0 2004	32. Registrar's Signat	ly A	ooks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar AMEND ITEM #20B&c PER FH G834e Silital Of Beath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 3 P M Antonio Matthews 2004 Augus /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Northwest Hospital Center andallstown ltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 39 Yrs. 8. Date of Birth 9. Birthplace (State or Foreig **Funeral** 216-84-6434 Usual Residence of Decedent Days 1 M 2□F Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
ant: If item 27 is marked other then "netural, or Items 23e or 28e-f show unt: If item 27 is marked other the "netural", or Items 25e or 28e-f show unty or other treumatic event, Ite Medical Evaninar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 10e. Street and Number 1 Yes 2 □ No Completed by Funeral Director more 10f. Zip Code 10g. Citizen of What Country? more Kd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) Fither) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition Department of H Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 17. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, box, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Multiple organ system Physician >72 hours disease or condition resulting in death) /Medical Due to (or at a consequence of): Examiner stemic intlammaTor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examine Staphlozocal
Due to (or as a consequence of): bacheremi physician ar Division of Vital Records, P.O. Box 68760, Recreationa Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the ald 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemio 3 Probably 4 WUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? nepatitis 24a. Was an autopsy performed Bipolar disorder 2 No 2 No 1 Yes To the Hospitel or Attending Physicien: 25. s case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 2 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 (Natural 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28462

Registrar

State

Randallstown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 1 0 2004

thwest

32. Registrar's Signature

			_ roi	partment of Health and Mertificate of Death	lental Hygie	2001 2510-	7							
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death								
	/Medic Examir		Richard Carlton Myer 4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel	August 6	4c. County of Death Prince Georges	IVI							
	Funeral Director		5. Social Security Number 577-12-3350 6. Sex 1 Age (In yrs. last birtho	Months Days Hours Min	8. Date of Birth Month, Day, Ye JAN 20,	9. Birthplace (Size of Four Country) DISETT of Columbia	ign C'I							
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Medical Exertinate until build of all of the recommendations.	leted by Funeral Director	10a. State 10b. County 10c. City, Town of Maryland Prince Georges 10c. City, Town of Maryland Prince Georges 10c. City, Town of Maryland 12c. City, Town of Court 15604 Darwin 12c. Was Decedent Ever in U.S. Arged Forces? 12c. Was Decede	Laure1 10f. Zip Code 20707 3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: Decedent's Usual Occupation five kind of work done during most of works.	ecify Yes or No- Rican, etc.)	10d. Inside City Lim 1 □ Yes Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: White								
	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the Ma	To Be Completed	Flementary/Secondary (0-12) College (1-4or 5-)		(First, Middle, Maid	Paint den Sumame)								
Baltimore, Maryland	permit. Pages 1 and 2 shoul Department of Health and Me Important: If item 27 Is mark eny injury or other treumati <u>once.</u>	T	T	Ē	19a. Informant's Name/Relationship (Type, Print) William C. Myers/son 156 20a. Method of Disposition 1	ailing Address (Street and Number or Rura 04 Darwin Court La	of Maryla	20707 Location - City or Town, State Baltimore, MD						
8760,	Associated transit and transit	ed by Physician/Medicai Examiner	dicai	Completed by Physician/Medical Examiner	dicai	dicai	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypoxemic Hypero Due to (or as a consequence of). Pneumonia Due to (or as a consequence of). COPD Exacerbatio Copplication of the consequence of	enter the mode of dying, such as cardiac cardi	or respiratory arrest,	Approximate Interval Between Onset and Death 1 Week 4 Weeks 1 week 2 weeks				
P.O. Box 6	the death certific y the attending p Iched for use as I						nysician/Me	nysician/Me	ıysician/Me	ıysician/Me	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	
	quires that the de in signed by the a uld be detached f				Part II. Other significant conditions contributing to death but not resulting in the Ischemic Cardiomyopathy	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?						
al Records,			Atrial Fibrillation		24a. Was an autopsy performed		ole of							
Division of Vital	ding Phys n. After this funeral dir	Certification; To Be	tification; To Be	2	25. Was case referred to medical examiner? 1	e of 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 28d. Describe how in	and Number or Rural Route Number.						
۵	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director:	Medical Ce	29a. Certifier (Check only one) 29 Medicel Examiner: On the best of my knowledge, of the desire of examination and/of and manner stated.	eath occurred at the time, date and place, a rinvestigation, in my opinion, death occurre	and due to the cause ed at the time, date	e(s) and manner as stated. and place, and due to the cause(s)								
	To the within To the comple	Me	29b. Signature and title of certifier PHY SICIAN 30. Name and address of person who completed cause of death (Item 23a) (Ty MINTEL PATAILO, M. J. L. L. H.	29c. License number 50057211		Date signed (Month, Day, Year)	_							
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Tymu Uhree Portable M. J. L. L. H. 31. Date filed (Month, Day, Year) 32. Registrar's Stanature	7300 VAN DUSEA	RD, Lo	turner mo 207	07							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1810 oscoe 200 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Barriew Medical Center altimore If Under 24 Hrs. 8. Date of Birth (Month, Pay, 9. Birthplace Country) **Funeral** Days Min. 1 MM 2□ F Director 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itema 23a or 28a-1 show the Medical Examinar must be notified at GWYNN 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after T⊟Yes 2 No If Yes, Give Year or Dates: 1 Never Married Baltimore, Maryland 21215-0036 1 🗆 Yes 25.00 þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. (0-12) College (1-4or 5+) orrectiona 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked o 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwynn Oak 20c. Lo 20b. Place of Disposition (Name of cometery, crematory or other) Method of Disposition Burial 2 Cremation 3 Removal from State 8-11-04 * 4 ☐ Donation 5 ☐ Other (Specify) permit 21. Signature of Funeral Service Licensee Greene Funeral Sinc. BUY kandallstown MO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician SEPSIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner -transit and physician ar Due to (or as a consequence of): P.O. Box 68760. Physician/Medical as the attending IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by 3 ☐ Probably 4 Unknown 1 🗌 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo 1 Inpatient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attanding 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🟂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES - 000 AUGUST 5, 2004 30. Name and lody ss of person wh completed cause of death (Item 23a) (Type, Print) RIZWAN HAQ, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN AVENUE, BALTIMORE

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year,

AUG 1 0 2004

32. Registrar's Signature

04-507 B.K.S			Please	Type or Print	in Black	Indelible Ink.	Ensure Al	l Copies A	re Lec	aible.		
	ra K. N	10F	GAN			partment of H		-				
1	Innend	it	For Stete #23a, 27, 2	8a-f,per MR					0 SN.	04	251	39
	Physici /Medic	an	1. Decedent's Name (First, Middle, La	erta K. Mor		23,04 11		2. Date of Death Month AUG • 5	Day 200	Year)4	3. Time of 0933	
20	Examin		4a. Facility Name (If not institution, gi 200 1st AVENUE			Bal	Location of Death		BAI	nty of Death		
1804	Funeral Director				In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, DEC 19,	1958	9. Birth	olace (State on ntry) linois	r Foreign
	Maryland e-f show ilied at	tor	10a. State 10b. County	Arundel 1	Oc. City, Town o	r Location Severna	Park				10d. Inside C 1 ☐ Yes	17.7
:	In with the 23e or 28e	Funeral Directo	10e. Street and Number 241 Lower Mag	othy Beach l	Road	10f. Zip Code	1146	10	-	of What Cou JSA	ntry?	
920	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Health and Mental Hygiene. The Hygiene are 27 is marked other then "netural", or Items 23e or 28e-f show tother treumetic event, Ite Medical Examinal must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ace - Ameri lack, White, cify: Wh		
Baltimore, Maryland 21215-0036	within 72 ho ene. then "netul ise Mad Gal	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)		(C	ecedent's Usual Occup Give kind of work done fe. DO NOT use retired Sales Mana	during most of work d)	ing		Business/Ir ming		
land 2	ld be filed ental Hygie ked other ic event, II	To Be Co	17. Father's Name (First, Middle, Las Emmett P. Morg		I	bares ridire	18. Mother's Name	First, Middle, N	laiden Sum		1001	_
, Mary	and 2 shou alth and N 27 is ma er treume		19a. Informant's Name/Relationship Kathleen M. Johr	(Type, Print) Ison/sister		Mailing Address <i>(Street</i> L Lower Mag						2114
imore	permit. Pages 1 a Department of He Importent: If Item eny injury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		cemetery,	isposition (Name of crematory or other place Crematory or other place Crematory,	Inc. 8/7	7/04	Balti	n-City or T More,	MD	
Balt	Departi Departi Importi eny inj		21. Signature of Funeration and U.S. McI	monald bould	<u> </u>	22 Name and Addre Cremation 299 Freder	ss of Facility Society of ick Road	of Maryla Baltimo	nd, I	nc. D 21 2	28	
9	nysician		23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.		t enter the mode of dyir Alprazolan			st,		Approximat Interval Bet Onset and	ween
	/Medical Examiner	Ļ	resulting in death) Sequentially list conditions, if any, leading to immediate	b	consequence of)							
	axecuted and al-transit	Examine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of)							
Box 68760,	death certificate be executed e attending physician and nd for use as the burial-transii	edical	,,	d								
P.O. Box	it the death certific by the attending p tached for use as i	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 □ No 9 ★Unknown							Date of deliv Month		Year
	as tha	by	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cause giv	ven in Part I.	23e. Did tob	1		the cause of d	
ital Records,	9 - 9	Completed						24a. Was ar autops perform 1 X Yes 2	/	b. Were aut prior to co death? 1 D res	opsy findings ompletion of c	available ause of
ita	cien: Th ertificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	9)			

To the Hospitel or Attending Physicier within 24 hours after death.

To the Funerel Director: After this certif completely filled in by the funeral directo Division of Vit m Certification: To

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE

28a. Date of Round (Month, ay Year)

8/4/04

9:00 a M 1 Yes 2 No Subject ingested prescription

Subject ingested prescription

28f. Location (Street and Number or Rural Route Number,

260° IST Stree

Baltimore County, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Found in house**

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

5 Pending

investigation 6 Could not be determined

> 29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) AUG • 6, 2004

Penn Street, Baltimore, Maryland 21201

State Registrar

AUG 1 0 2004

31. Date filed (Month, Day, Year)

1X Yes _2 □ No

27. Manner of Death 1 Natural

2 Accident
3 Suicide

29a. Certifier (Check only one)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene PER FH G834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:10 PM **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Parkville
If Under 1 Year | If Under 24 Hrs. BALTIMORE last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 20 F -34-668 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or Items 23a or 28a-f shov the Medical Examinar must be notified at 1 Yes 2 No Funeral Director BALTIMORE PARKVILL MA 10e. Street and Numb 8800 WALTHER BLVD 10f. Zip Code 10g. Citizen of What Country? USA 2123 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 PNo Maryland 21215-0036 Specify: White. Completed by 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be 2 should be f and Mental H Dowditch Vel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Importent: If Item 27 1s
any injury or other trau 1000 son, MD 21286 20b. Place of Disposition (Name of cemetery, grematory or other place)

EVANS FUNE (ALCHAPE) 20a. Method of Disposition
1 Burial 2 Cremation 3 B
4 Donation 5 Other (Specify) 20c. Location - City or Town, State 3 Removal from State -8-9-04 Forest Hill, MD 22. Name and Address of Facility YORKL RD., TIMONIUM MD 21093 21. Signature of Funeral Service Licenses PEACEFUL ALTERNATIVES FUNERAL + CREMATION CTR Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Fina disease or condition resulting in death) emen tra Pnysician West H /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No 24a. Was an autopsy 2(7 1∐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: sing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28c. injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a To the Funerel C To the Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D53111 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Per kv-lh 5000 mo walth Landino 31. Date filed (Month, Day, Year) AUG 1 0 2004 2. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Laura Ruth Montgomery 7:00 A 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cartonsville har timore Y WO If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7 Ane (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 □ M Yrs. 218.16.0151 86 Director Maryland April 8, 1918 Usual Residence of Decedent with the Maryland 10d. Inside City Limité 10a. State 10b. County 10c. City, Town or Location "natural", or Itams 23a or 28a-f show the Nedical Examiner must be notified at by Funeral Director Howard Ellicott City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21042 U.S.A. 3341 N. Chatham Road death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or lite ury or other traumatic event, the Neulical Examentry or other traumatic event, the Neulical Exament 1/ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Beauty Parlor** Elementary/Secondary (0-12) College (1-4or 5+) Reautician 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Ferguson George Homer Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3341 N. Chatham Road Ellicott City, Maryland 21042 Sister Ms. Jane Cahill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or *4 Donation 5 Dother (Specify) Entombruent 08/06/2004 Brentwood, Maryland Fort Lincoln Cemetery permit. 21. Signature Funeral Service Cer see 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atherosclero Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year įõ Month Day 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. γ 3 Probably 4 Juknown 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 1 🗆 Yes certificate 1 ☐ Yes 2 1 No Fo the Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one, Be Hospital: 1 Inpatient Other: 4 Horsing Home 5 Residence 6 Other (Specify) 10 1 Tyes 2 1 NO 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Hatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending within 24 hours after deavi.
To the Funeral Director: Aft 1 🗌 Yes investigation 2 Accident Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie August 4, 2004 erson who completed ause of death (Item 23a) (Type, Print) Baltimore MD21228 711 Maiden hilli Lane tone 31. Date filed (Mortin, DAUG 1 0 Day, Year) 2004 32. Registrar's Signature State

DRMR 17 Rev 1/200

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** OriA 0405 446-457 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO-If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Months Days **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "natural", or iteme 23a or 28e-f ehow traumatic event, the Madical Examiner rivast by notified at Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 Mo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Dovidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "na any injury or other traumatic event space. Elementary/Secondary (0-12) College (1-4or 5+) COUNSELOY 1211 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sun Be 19b. Mailing Address (Street and Number or Rural Route Number, City or 19a. Informant's Name/Relationship (Type, Print) 3003 D 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failude. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aural Immono de fraces /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2.0 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 20 No 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/2004 40854

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

KI

31. Date filed (Month, Day,

301

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:20 P M Alvin Wilson Newton, Jr. Ju₁v 31 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7335 Forest Avenue Hanover Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1 XM 2 ☐ F 16,1937 228-44-7198 VA Director 67 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** Anne Arundel Hanover 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7335 Forest Avenue 21076-1152 U.S.A. deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) , or items 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If liem 27 is marked other than "natural", or fler eny injury or other traumatic event. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electrician Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alvin Wilson Newton, Sr. Beatrice Virginia Gallahan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7335 Forest Avenue, Hanover, MD 21076-1152 Mrs. Carol A. Newton / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Aug 5, 2004 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signatur of Funeral Service Licensee M01220 1 Second Avenue S.W., Glen Burnie, MD 21061 23a. Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** CAMCE 014 41 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or in jury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician Box 68760 the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ be 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 1 No 24a. Was an autopsy certificate has page 2 Hy vert 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case refer ed to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2 FR/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DR. SHOBHAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 OAKWOOD RD 3Te 304 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

AUG 1 0 2004

				State of Maryla	_			Mental Hygi	iene	
			1 - State Registrar		Ce	rtificate of	Death		g. No.	25144
	Physici	an	Decedent's Name (First, Middle, Last)	1 - 16 -	No1-			2. Date of Death Month	Day Y	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give si	treet and number)	1001	11 12 12	or Location of Dea	AUGUST	4c. County of	104 3:35 F ^M
	Examin	er	Saint Joseph M		nter		Tows			ltimore
	Funeral		Social Security Number 6. Sex	7. Age (In yr.	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9	Birthplace (State or Foreign Country)
	Director		210-10-0010	M ZLIF	34 Yrs.			7-19-0	05 n	PARYLANDS
	land land		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
	Mary I sh	tor	MD BALTIMO	0F	Time	onium				1 ☐ Yes 2 No
	or 28s	irec	10e. Street and Number	0.		10f. Zip Code		10	g. Citizen of Wha	at Country?
	ath wi	rai	& Koundridge	Rd.		21	093		USI	4
	er de	Funeral Director		Was Decedent Ever in Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc.
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show Its M. cifel Examiter challe encilled at		15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Busin	ness/industry
21	within 7 ene. than "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1/4or 5+)		DO NOT use retire		orking	01.	
	e filed wall Hygier other th		17. Father's Name (First, Middle, Last)	4	Jale	est Hd	vertisi	ng	Kadic)
and	id be fi ental H ked ot	Be	JAMES K. 10	14 50			18. Mothers Na	me First, Middle, M	faiden Sumame)	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. if item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event, II is M. offel Examiner of the neitled at	2	19a. Informant's Name/Relationship (Typ		19b. Mailie	ng Address (Street	and Number or R	TUR 170	City or Town, Sta	ate. Zip Code)
	1 and 2: Health ar em 27 is		Eleanor H. Nolto	e-mother	- PROL	indrida	Rd. Ti	MONIUM	MA 21	093.
altimore,	es 1 a of Hea fitem r othe		20a. Method of Disposition	20b.	cemetery, crei	sition (Name of matory or other pla	(ca)	Date 2	Oc. Location - Cit	ty or Town, State
Ĕ	Pages ment of ant; if it ury or o		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)	Miloval from State	JaneyVa	lley Mem	Gar. 8-	10-04 5	Timonic	mmo
Balt	permit. Pages Department of Important: if i any injury or o		21. Signature of Funeral Service License	3 +	22	2. Name and Address 2325	YORK R	P., TIMOR	lium m	00 21093.
	00360		23a. Part1. Enter the disease of complete	way	Pt	ACKFULT	HLT ERRUH	TIVES I-L	NERHL +	CLEMATION CITA
			shock, or heart failure. List on one	e cause on each line.			ng, such as cardia	ic or respiratory arre	51,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	END STAGE		STAGE				6 MONTHS
b	Examiner		Cognestially list conditions h	GASTROINT		AL BLEET)			
	P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to (or as a conse	equation of):					
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events c							
8760,	icate be executed physician and s the burial-transit			Due to (or as a conse	aquence or).					
687	ficate p physis the	edicai	d.							
Вох	death certifi e attending f id for use as	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg		76			23d. Date o	f delivery
		Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnance Other (specify)	y 		Month	Day Year
P.0	at the	Phy	9 Unknown					00- Bides		
JS,	es be	by	Part II. Other significant conditions conf	mound to death but not re	esuiting in the u	nderlying cause giv	ven in Part I.	238. Did tobs		ite to the cause of death? ☐ Probably 4 ☐ Unknown
Sor	> 4	etec							-	
Records,	e tar has	Completed						24a. Was an autopsy perform	prio dea	
Vital		0	25. Was case referred to medical				26 Place of De	1 ☐ Yes 2, ath (Check only one		Yes 2 No
fΝ	Physician: this certific ral director.	To B	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatier	10 AOO OU	ner	Home 5 Resider		(Specify)
n of			27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	ry at	28d. Describe how	w injury occurred	
sio	Attending r death. ector: After y the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	CO. Division to			Yes 2 ☐ No	0011 11 10		
Division	in the o	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		City or Town,		or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	aj C	29a. Certifier 1 Certifying Phys	ician: To the best of my ki	nowledge, deatl	n occurred at the til	me, date and place	e, and due to the car	use(s) and manne	er as stated.
	n 24 t n 24 t ne Fu	edical	(Check only 2 Medicel Examin one)	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	opinion, death occ	urred at the time, da	te and place, and	due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	,		29c. Licens	se number	29	d. Date signed (A	Month, Day, Year)
	,		Ma XSI	tra		DØØØ	31674		8/7/	04
	5		30. Marrie and address of person who cor	mpleted cause of death (It	em 23a) (Туре, "	Print)			,	
	Sta	to	31. Date filed (Month, Day, Year)	72. Registrar's Sign	7601.0	SLER DR	TUE, TO	WSON, M	ARYLANI	21204
	Registr		AUG 1 0 2004	Begins	De 1	sports				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2:25 PM 7004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Barrier Medical Contr Baltimore Johns Honkins If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Country) Funeral 3450 34-34-3450 Usual Residence of Decedent Days 1 M 20 F ω 7 Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or Itema 23a or 28a-f ehow injury or other traumatic event, the Medical Examiner must be notified at atonsville 1 ☐ Yes 2 No Director 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Z ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event the Means in the Means Elementary/Secondary (0-12) College (1-44r 5+) Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8H65 Horono RD. Round Horono RD. Round Horono RD. Pate 20c. Location - City or Town, States representing for all pates. 19a. Informant's Name/Relationship (Type, Print) Angelina-Anthony (Daughter) 8405-Haraho RD. 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State -30-04 Arlington, VA Greater while I Size. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugho C Ustown WD 21133 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0-900 Physician Due to (or as a consequence of): 18 hours /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0515 Due to or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☐Unknown Completed YETAM MENIUMEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No Inpatient 2 ☐ ER/Outpatient P 1 🗌 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 Yes 2 No 2 Accident completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MO PLO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

AUG 1 0 2004

L.Christin -31. Date filed (Month, Day, Year)

Bayic. 32. Registrar's Signature

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:00 AM 2004 Inez Nelda Pownell MAL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bon Ko 65 P Franklin Squal 1 to Se. 0 -1 mo1 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, March 24, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Year) Days Months Hours 1936 West Virginia 1 M 2 SF 68 296-32-6465 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State "natural", or Items 23e or 28e-f show 1 Yes 2 No Directo Baltimore Maryalnd Middle River 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21220 U.S.A. 12 Gyro Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 TNo If Yes, Give Year or Dates: 1 □ Never Married 2 N Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is marked other than 12 Home Maker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be f Health and Mental 8 Virginia May Snyder Oscar Ray Kalar Marvi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Gyro Drive, Baltimore, Maryland 21220 Philip Pownell, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō Important: If it any injury or c 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gar. Aug. 7, 2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of uperal 3 vice Licensee 22. Name and Address of Eacility
Bruzdzinski Funeral home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in eath) Metastat Priysician concel /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence of: Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1 Yes 2/ No Division of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 EP/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☑ No 27. Manner of Peath 2 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tniury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Funeral Dir | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

AUG 1 0 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 12:14 P.M **Physician** PRICE MAXINE JANICE ugust 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTBOURNE Avenue BALLIMONE
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Year) 5-17-19 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F 212-46-0448 6 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show treumatic event, the Medical Examiner must be notified at 1XYes 2 No Director 3A/41MORE MARYIAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21224 U.S.A Items 23c 259 Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐ Yes 2 Yes, Give 2 No 2 Married 1 Never Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced Year or Dates: "natural', Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Future CARC Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12 JURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MAC HISHER KALPH RICE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 siment of Health an HighlAND Department of Health a Importent: if item 27 is any injury or other tre Once. LEON N. PHILLIPS - HUSBAND 2595. HUENUC SAHIHORE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State eternals Centery Aug 12, 2004 Owings MILLS MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Ingral Service Licenses 22. Name and Address of acilla Fuveras JR. NINO 263 5. CONKLING STREET BALTOMDZIZZY or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disc s shock, or heart faire. Immediate Cause (Fi al Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): the attending physician Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Po 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Momicide 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 120MM15 04793

Registrar

State

501

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 1 0 2004

			1 - For State Registrar	State of	of Marylan		artment o				iene g. No. 00	+ 2	25148
	Physici	ian	1. Decedent's Name (First, Midd Rita H.	Parrish						2. Date of Dea Month	Day Y	/ear	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution		ımber)		4b. City, Tow	vn, or Location	n of Death	August	5, 2004 4c. County of		2:37 P [™]
	LAGITIII	101	Greater Balti	more Medi	cal Cent	er	To	wson			Balt	imore	2
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.		If Under 1 Y Months Da	ear If Unde	er 24 Hrs. Min.	8. Date of Birth (Month, Day	Year) S	Birthpla	ace (State or Foreign
	Director		212-03-6408	1 L M 261F	85	Yrs.	Months	ays Hours		March 1	7, 1919		ryland
	and	1	Usual Residence of Decedent 10a. State 10b. Count	,	10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits
	Maryl	ō	MD Ba	timore	C	ockeys	171 110						1 ☐ Yes 2 X No
	death with the Maryland ms 23e or 28e-f show rmust be notified at	Director	10e. Street and Number	CIMOIC	0	ockeys	10f. Zip Co	de		1	0g. Citizen of Wh	at Counti	y?
	h with		606 K Kno	.1 Crest P	lace		21	1030			USA		
	deat	Funerai	11. Marital Status		edent Ever in U	.S. 13.			Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race -		
2	d 21215-0036 filed within 72 hours after death with the Marylar Hygiene. thygiene. wher than "natural", or Items 23s or 28s-f show ont, the Madical Evan instrument by notified at		1 Never Married 2 Ma	ried 1 ☐ Yes If Yes, G	2 X No īve		1 ☐ Yes 2 🛣				Specify:		
7	hours tural;	ed by	3 Widowed 4 Divorce		Dates:	16a Dasa	dentia Haval O						
7		Completed	(Specify only high	nt's Education est grade completed		(Give	dent's Usual O kind of work do DO NOT use re	ccupation one during mo etired)	ost of workin	ng	16b. Kind of Busin	ness/indu	istry
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	laryiand 2121 2 should be filed within and Mental Hygiene, is marked other than aumatic event, the Ma	Bec	17. Father's Name (First, Middle	Last)					her's Name	(First, Middle,	Maiden Sumame)		
3.	arylai should b and Ments marked umatice	10	Francis X. H	lohman				E1	izabe	th Clar	k		
5.			19a. Informant's Name/Relation			4					; City or Town, St		•
			Frank S. Parris 20a. Method of Disposition	h/Husband	20b. F	lace of Dispo	osition (Name o	of I	D	ate	ysville, 20c. Location - Ci		
2	S to E L		1 Burial 2 Cremation 3 4 Donation 5 Other (State Ba	emetery, crei Ltimore	matory or other e Washi	ngton	Auguš	t 9,			
4			21. Signature of Fuseral Pery		Cr	emator	2. Name and A	ddress of Faci	ility	2004 _	Laur		
	Balt permit, Departr Imports any inj		1	ichael J.	Flagle	Le	emmon F	uneral	Home	of Dul	aney Val	ley,	Inc.
				r complications that	caused the deat	h. Do not ent	ter the mode of	dying, such a	is cardiac o	r respiratory arr	est,	1	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	2	A	RRYTH	min					2	nset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq					7	erro my		
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a conseq	uence of):				19			
	60, be executed siclen and burlal-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1				100	191	(See	e		
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	ate y L	edicai		d				~~~//		·			
(Box 68 eath certific attending pl	/Me	IF FEMALE:	23c. If yes, or	itcome of pregna	ancy		/	10×				
	Box leath cert attending	clan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	death 3	□Ectopic pregn □ Other (specif)		/0		23d. Date of Month		yay Year
1	that the deed by the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkr									
~	IS, P	by P	Part II. Other significant condit	ions contributing to d	death but not res	ulting in the u	inderlying cause	e given in Part	t I.	23e. Did tot	pacco use contribu	ute to the	cause of death?
•	cord w require been sl			Lymph	oma					1 🗆 Ye	s 2000 3	Probat	oly 4 □Unknown
	Heck he law r has be ge 2 sh	Completed		Osteo	00120515					24a. Was a autops	y pric	or to comp	y findings available pletion of cause of
	The The cete has	Con		Lupus						perform	ned? dea	ath?	N o
	Vital Fician: The certificate rector, pag	Be	25. Was case referred to medic examiner?	Hospital:				Othor		(Check only on			
,	Of Phys	. To	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	-	4 🗆 🗅			ence 6 Other		
	ion nding th. : Afte e fune	tion	1 ZNatural 5 ☐ Pend		nth, Day Year)	Injury		Injury at Work? 1 Yes 2			,,		
	Division of Vital Records, to Attending Physician: The law requires after death. Director: After this certificate has been sign the tuneral director, page 2 should be	ertification:	3 ☐ Suicide 6 ☐ Could	nined 200, Plac	e of Injury - At h	ome, farm, str	reet, factory, off	fice	2	8f. Location (St City or Town	reet and Number	or Rural I	Route Number,
i	Di Ital or rs afte ral Dir	Cert											
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director.	edical	29a. Certifier 15 Certify (Check only 2 Medica	ng Physician: To th I Examiner: On the I and mar	e best of my kno basis of examina nner stated.	owledge, deat tion and/or in	h occurred at the vestigation, in r	ne time, date a my opinion, de	and place, a eath occurre	and due to the ca ad at the time, d	ause(s) and mann ate and place, and	er as stat d due to ti	ed. ne cause(s)
	To ti To ti comp	M	29b. Signature and title of certifi	ər			29c. Lie	cense number		2	9d. Date signed (/	Month, Da	ay, Year)
	\		15/20	mo			1	23736	,2		8/6/4		
	V		30. Name and address of person		ise of death (Iter			Herrin	د مریار	md 2:	092		
	St	ate	31. Date filed (Manth Pay, Ye		Ragistrar's Signa		Low	4					
	Regist		710012			10	Moore	Key					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month Year **Physician** Deborah Powe11 Lee 2004 109051 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Stella Maris Hospice At Mercy Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 26, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2√xF 212-02-8759 21 Yrs Director 1982 Maryland Usual Residence of Decedent iled within 72 hours after deeth with the Maryland 10a State 10b County 10c City Town or Location 10d, Inside City Limits 28e-f show treumetic event, the Medical Examiner must be notified at Maryland Completed by Funeral Director 1 Yes 2 No Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4420 Parkmont Avenue 21206 USA Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 至⊠ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ₩ Never Married 2 Married ō 1 ☐ Yes 2 ☑ No Specify White 3 ☐ Widowed 4 ☐ Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry 2 should be filed with......h and Mental Hygiene. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnny Powe11 Sheila Marie Stenci1 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Importent: If item 27 is any injury or other treum once. Sheila Powell Mother 4420 Parkmont Avenue Baltimore, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore-Washington permit. Page Department of * 4 ☐ Donation 8/10/2004 Laurel, Maryland Crematary 22. Name and Address of Facility neral Service Lice 21. Signature Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lementate Court (First). Approximate Interval Between Onset and Death Immediate Cause (Final erebronswlar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner endo cord Sequentially list conditions, it may be used to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequent Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No P.O. 9 Onknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s certificate 2 🗆 No 2 1 No 1 ☐ Yes Division of Vital 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 1 🗌 Yes 2.2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. The and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (MonA) 16. Year 0 32. Regierrar's Signature State Registrar

ALBERT PULLEY State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Albert B. Pulley JULY 29, 2004 1:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A 3601 PARKVIEW AVENUE APT.C BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG 2, 191 5. Social Security Number **Funeral** Birthplace (State or Foreign Country) Months Yrs. Director 251-16-2178 Ünk Usual Residence of Decedent with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or Items 23e or 28a-f shov other traumetic event, the Madical Examinar must be malified at Marvland Baltimore Gwynn Oak 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3601 Parkview Avenue Apt. C 21207 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces?

12 Yes 2 No. If Yes, Give WWII Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Black Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working
 life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk. Unk. Unk. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental I eq pinous Unk. Unk. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it. Pages 1 and 2 strument of Health and rtant: If item 27 is n Myra Rhone/friend 3809 Hilton Road Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ö Metro Crematory, Inc. 8/6/04 Baltimore, MD injury 4 ☐ Donation 5 ☐ Other (Specify) permit.
Departm
Importa
eny inju 21. Signature of Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy j in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.0. sate has been signed by the a page 2 should be detached by 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 Yes 2□ No 1 Yes director. 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 XYes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA AT SCENE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) JULY 30, 2004 title of certifier 29c. License number 29b. Sig albre an O.C.M.E dress of person who completed cause of death (Item 23a) (Type, Print) LAND 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State AUG 1 0 2004 Registrar

			T = For State	State of N	Maryland / Depa	artment of rtificate or			all the second	
			Registrar 1. Decedent's Name (First, Middle,	Last)		tineate of	Death	2. Date of De	Reg. No.	3. Time of Death
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>	/Medi Examir		4a. Facility Name (If not institution,		r)	4b. City, Town,	or Location		4c. County of Dea	
	=		Sinai Hosp:	ital		Balt	timore		N/	
	Funeral		5. Social Security Number		ige (In yrs. last birthday)	If Under 1 Yea				thplace (State or Foreign
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	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	antina		110771	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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	eath	era	11. Marital Status	12. Was Deceden	t Ever in U.S. 13	212		gin? (Specify Ves or No	USA 14. Race - Ame	rican Indian
10	fter d r ften	F	1 Never Married 2 Marrie	Armed Forces	6?	f Yes, specify Cu	ban, Mexicar	gin? (Specify Yes or No n, Puerto Rican, etc.)	Black, Whit	e, etc.
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21215-0036	72 hours after death with the Maryland netural', or items 23a or 28e-f show dies! Examiner must be notified at	Completed	15. Decedent's			dent's Usual Occi			16b. Kind of Business/	
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Va	should be and Mental s marked o	2	HAROLD Pringl	е			Thr	essa High	smith	
Maryland	0 0 0	0.2	19a. Informant's Name/Relationshi			g Address (Stree	at and Numbe	er or Rural Route Numb	er, City or Town, State, 2	Zip Code)
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Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Juneral Service/Li	nsee	22	. Name and Addi	ess of Facilit	Y Chatman	-Harris Fi	uneral Hom
_	<u>ಹಿ</u> ದಿ = ಕ ನ		Mra the	1-1-	5	240 Rej	ster	stown Rd	Baltimore	, Md 21215
			23a. Part1 Enter the disease, or c shock, or hear failure. List or	omplications that cause nly one cause on each	line.	er the mode of dy	ing, such as	cardiac or respiratory a	rrest,	Approximate Interval Between
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8760,	cate be executed physician and the burial-transit	Ë		Due to (cir a	s a consequence of).					
87	ate hys	dicai		d						
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy					
Вох	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnand	су		23d. Date of deli Month	very Day Year
O.	at the de by the a tached	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	at time of death 3_	Other (specify) _				•
<u>α</u>	that I		Part II. Dther significant condition	s contributing to death	but not resulting in the ur	derlying cause g	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
ds	sign d be	d by				, ,		101	,	obably 4 Unknown
Ö	w require been si should b	ete								
Records,	The tav	Completed						24a. Was autop	an 24b. Were aut prior to c rmed? death?	topsy findings available ompletion of cause of
Vital		e Co	25. Was case referred to medical					1DX Yes	2□ No 1 Yes	2 No
Ξ		m	examiner?	Hospital:	0.000	ot ot	hor	of Death (Check only o		
of	Phys	T: To	27. Manner of Death	28a. Date of Ini	ury 28h Time of	3 DOA	4 NUI		dence 6 Other (Spec	ify)
on	iding I th. After funer	tior	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, D	a <i>y Year)</i> Injury	28c. Inju Wo	ork?]Yes 2.[X N	G lainet	Shot and	assaulted
Division	of or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Ir	njury - At home, farm, stre	1	, ,	0	Street and Number or Rui	ral Route Number
Ö	Z in in in	Certification:	4 Homicide determini	building, e	tc. (Specify)	0110.			RC State)	un Road
	Hospitel or 24 hours afte Funerel Dir tely filled in I	1 1	29a. Certifier 1 ☐ Certifying	Physician: To the bes	of my knowledge, death	occurred at the t	ine, date and	place, and due to the	cause(s) and manner as	stated.
	ne Ho	edicai	(Check only 2 Medical Ex	aminer: On the basis of and manner s	of examination and/or inv	estigation, in my	opinion, deat	h occurred at the time, o	date and place, and due	to the cause(s)
	To the Hospitel of within 24 hours all To the Funerel D completely filled in	Me	29b. Signature and title of certifier		^ ^	29c. Licen	se number		29d. Date signed (Month	Day, Year)
•	2		1/at ()	~ - K	VO2		O.C.M	I.E.	July 27, 20	004
	19		30. Name and address of person with	no completed cause of	death (Item 23a) (Type, I	Print)				
			PATRICIA Aro	NiCA- To			Street	, Baltimore	e, Maryland	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	,			-	
	Registr	ar	AUG 1 0 2004	Agnetic	· B So	racket				

		-	For State	State of Marylan		artment of F		d Men		0	0.0	1	05150
			Registrar		Cei	runcate or	Dealli	121	Date of Dea	Reg. No./	لالا	4	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)	1/		De- 1	/		Month	Day	Ye	ear	
	/Medic		Sanbara	/		Ich	LER	166	ugu	-		04	02:35 AM
}	Examin	er	4a. Facility Name (If not institution, give	street and number)	,	4b. City, Town, o	r Location of De	eath	1		ounty of I	Deeth	
			The Johns Hoa	Cens Hosphi	al	Balto	none	Ci	Ly		/A		
	Funeral		5. Social Security Number 5/ Se	7. Age (In yrs.	last birthday)	Months Days	If Under 24 H		Date of Birti (Month, Day	h y, Ye <i>ar</i>)		Coun	ace (State or Foreign try)
	Director		184-40-9999		Yrs.			A	pril	28 , 1	951	NY	
	2 >	-	Usuel Residence of Decedent 10a, State 10b, County	10c Cit	ty. Town or Le	ocalion						10	Od. Inside City Limits
	show	_	Maryland N/A		ltimor								1X Yes 2 No
	Ba-f.	cto			LCIMOL								
	or 21	Director	10e. Street and Number			10f. Zip Code			-	10g. Citize	n of Wha	al Coun	try?
	be filed within 72 hours affer deeth with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23s or 28s-f show event, ite Medical Examiner must be motified at event, ite Medical Examiner must be motified.		831 South Ellwood	Ave.		2122					. S.		
	e	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of hilf Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify uerto Rica	Yes or No- an, etc.)	- 14		America White, e	an Indian, etc.
٥	be filed within 72 hours after ital Hygiene. Id other than "natural", or ite event, the Medical Experime.	F	1 Never Married 2 Married	1 ☐ Yes 2 🕱 No If Yes, Give		1 ☐ Yes 2 ☒ No				1	pecify:	TAT	hite
3	Surs.	by	3 X Widowed 4 ☐ Divorced	Year or Dates:							111.		
2	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation a completed)	(Give	dent's Usual Occup kind of work done	during most of	working		16b. Kind	of Busin	ness/Inc	dustry
2	u L	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)						
7	gien graft	0	12	5+	Spe	cial Ed T					ucat	ion	
g	e filed other vent, t	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (F	irst, Middle,	Maiden S	umame)		
ā		To E	Vincent Vencio				Auro	ora D	ippol	ito			
Maryland 21215-0036	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship (T)	γρe, Print)	19b. Mail	ing Address (Street	and Number o	r Rural R	oute Numbe	er, City or	Town, St	ate, <i>Zip</i>	Code)
	27 15 27 15 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Clare Pichler, da	iohter	83	1 South E	11wood	Ave.	Bal	timor	N N	m.	21224
ā,	of Health item 27 other tr		20a. Method of Disposition	20b.	Place of Disp	osition (Name of matory or other pla		Date		20c. Loca	ation - Ci	ty or To	wn, Stete
altimore,	Peges nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Crematory		3-09-	04	Ba	1tin	nore	, MD
Ē			21. Signature of Funeral Service Licens										,
Ba	permit. Departr Importa any inj		John S	2		Ambrose F) (T)	01007
			23a. Part1. Enter the disease, or comp	lications that caused the dea	Do not er	1328_Sulp	no such as car	rdiac or re	Spiratory a	rest.	118	MID.	Approximate
			shock, or heart tailure. List only of	ne cause on each line.	27.5		3,						Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a Depsis								0	Days
	/Medical Examiner		resulting in dealin	Due to or as a conse	quence of):							1	()
	- Automoti		Sequentially list conditions,		ania								Days
	P ==	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (or as a conse	quence of):								
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conse									
Ő,	e exe	ũ	resulting in country case	Due to (or as a conse	quence or):							1	
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai		d									
9	ng pl	Med	IF FEMALE:	-						1		1	
Вох	eath certific attending p	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		□Ectopic pregnanc	су			23	3d. Date Monti		ery Day Year
	dea ne att	Sici	in the past 12 months?	4 Pregnant at time of 9 Unknown	death 5	Other (specify)					1410114		Juy 104
P.O.	inat the death hed by the atter detached for u	Physician/Me	9 Unknown										
S, F	requires that the een signed by th hould be detache	by F	Part II. Other significant conditions co	intributing to death but not re	sulting in the	underlying cause g	iven in Part I.						he cause of death?
Ď	w require been signal							_	1 🗆	Yes 2	No 3	Prot	pably 4 □Unknown
2	> 40 0	Completed							24a. Was				opsy findings available impletion of cause of
Re	0 - 0	E			·				perfo 1 ☐ Yes	ormed? 2 1 No	de	ath?	25 X No
a	iclan: Th certificate rector, pag	Ö	25. Was case referred to medical		_		26. Place of	Death (-9-11
of Vital Record		8	evaminer?	Hospital: 1 K Inpatient 2[☐ ER/Outpati	ent 3 DOA	thor		5 ☐ Res		Other	(Specii	6)
o	Phys r this aral di	1: To	27. Magner of Death	28a. Date of Injury	28b. Time	of 28c. Inju		-	d. Describe				,,
on	Attending Phyrideath. sector: After this by the funeral	tot	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury		ork? ∐Yes 2∐No	,					
S	death. ctor: A y the fu	lica	3 Suicide 6 Could not be	28e. Place of Injury - Al	home, farm, s	street, factory, office	9	281			Number	r or Run	al Route Number,
Division	or A after Dire	ertification:	4 Homicide	building, etc. (Spec	city)	,			City or To	wn, State)			
_	Hospitel 24 hours a Funerel I	O	29a. Certifier 1 1 € Certifying Ph	ysician: To the best of my kr	nowledge, de	ath occurred at the	time, date and o	place, and	d due to the	cause(s)	and man	ner as s	stated.
	Hos 24 hc Fun Fun	edical		iner: On the basis of examinand manner stated.									
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier				nse number						Day, Year)
	T W T		1112	Dima		RE	5-000	0		Avaos	st 6	012	004
7	d,		MUZI	7 77.613		- Drieti	, 00			, ,			•
	10		30. Name and address of person who of M. Brand Drymmon	completed cause of death (It	em 23a) (Typ	REG	+ 201	time	ce . 11	0	212	28-	7-
			31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	ית אוני	Dell		- 1 in(
	Si	ate	ALIC 1 0 2004	Harder Bright and State	PARTE								

		For State	State of Mary		irtment of		-	2	nni.	25153
		Registrar 1. Decedent's Name (First, Middle, Last	(1)	061	incate of	Death	2. Date of De	Reg. No.	004	3. Time of Death
Physicia /Medic			eed				Month	Day	004 Year	9:30 A.M
Examin		4a. Facility Name (If not institution, give				or Location of Death	1	4c. C	ounty of Dear	th
		13301 New Acadia			Upper If Under 1 Yea	Marlboro	0.0.48			George
Funeral Director		5. Social Security Number 6. Se 190-24-7948		n yrs. last birthday) 73 Yrs.	Months Day		8. Date of Bird (Month, Da July 2	n v, _{Year)} 3 - 193	1 Pen	thplace (State or Foreign buntry) nsylvania
		Usual Residence of Decedent					1	, , , ,		no) I vanita
nylanı how		10a. State 10b. County		C. City, Town or Lo	cation					10d. Inside City Limits
Ba-f.	cto	MD Prince	George	Upper M						1 ☐ Yes 2 ∏ No
with th	Dire	10e. Street and Number 13301 New Acadia	Tama #100		10f. Zip Code			•	on of What Co	ountry?
eath vs 23	eral	11. Marital Status	12. Was Decedent Eve	rin U.S. 13 V	20774		pecify Yes or No	US.	A I. Race - Ame	erican Indian.
Substitute of the Maryland Substitute of the Maryland and Mental Hygiene. Is marked other then "nature!", or liems 23a or 28a-f show sumatic svent, it a Medical Examine must be notified at	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No	1		f Hispanic Origin? (S) Iban, Mexican, Puerto	o Rican, etc.)		Black, Whit	e, etc.
ours a	1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X ☐ N	o Spacify:		S	pecity: Wh	ıte
72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Deced (Give	tent's Usual Occ kind of work dor	upation ne during most of wor red)	king	16b. Kind	d of Business	Industry
within ane. then	du	Elementary/Secondary (0-12)	College (1-4or 5+)		roll Cle			To 1	anhana	Company
Hygie Hygie Ither		17. Father's Name (First, Middle, Last)	Ψ	гау	TOTT CT	18. Mother's Nan	ne (First, Middle,			Company
ld be ental ked o	To Be	William Vernon				Rose D			,	
shou and M mar umat	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Stre	et and Number or Ru	ral Route Numbe	er, City or	Town, State, A	Zip Code) 20774
and 2 salth a n 27 ls		Gary Reed / Husba				Acadia La				
of He		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. Place of Dispo cemetery, crer	sition (Name of natory or other p	lace)	Date	20c. Loca	ation - City or	Town, State
I. Pag tment tant: jury		`4 Donation 5 Other (Specify)			etery 8/6/				Maryland
permit. Pages 1 and 2 should be filed within 72 hos Departmen of Health and Mental Hygiene. In procream: if I tem 27 is marked other than "naturany injury or other traumatic svent, if a Medical sone.		21. Signature of Funeral Service Licen:	/ A /VI			tress of Facility F1			-	yland 20707
		23a. Part1. Enter the disease, or comp	olications that caused the							Approximate
Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.							Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a c	ry Hypert onsequence of):	ension					
Examiner		Sequentially list conditions	b							
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):						
xecute and Il-tran	xam	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of);					_	
ficate be executed physician and is the burial-transit	dical E		4							
ficate g phy: as the	a)		0.							
leath certific attending p	M/us	23b. was decedent pregnant	23c. If yes, outcome of p]Ectopic pregnar	ncv		23	d. Date of de	
e deat	Physician/M	in the past 12 months? 1 Yes 2 No	4 Pregnant at tim		Other (specify)				Month	Day Year
uires that the de signed by the a		9 ☐ Unknown Part II. Other significant conditions or	ontributing to death but o	not resulting in the u	nderhing cause	owen in Part I	23e Did t	obacco us	a contribute to	the cause of death?
signe d be c	d by	Takii. Otilot significant oshlarions o	Diabetes		nderlying cause	given in raits.				robably 4 Dunknown
w requir been si should	iete		Renal Fa				24a, Was	an	24b Were a	utonsy findings available
sician: The law certificate has t irector, page 2 s	Completed		Kenai ra	allule			auto	rmed?	death?	utopsy findings available completion of cause of
an: T	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 L Yes	2 No
nysici	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	Other	lome 5∏Resi		Other (Spe	icify)
ng Pt Itter th		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time o	V	ijury at Vork?	28d. Describe	how injury	occurred	
tendi leath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	a			Yes 2 No	00()	01		
or All	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (- At nome, tarm, st Specify)	reet, factory, offic	CB CB	City or To	wn, State)	Number or H	ural Route Number,
spital lours neral filled		29a, Certifier 1 X Certifying Ph	ysician: To the best of r	ny knowledge, deat	h occurred at the	time, date and place	, and due to the	cause(s) a	nd manner a	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical Examone)	niner: On the basis of ex and manner stated	camination and/or in	vestigation, in m	y opinion, death occu	rred at the time,	date and p	lace, and due	e to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifies	201		29c. Lice	ense number		29d. Date	signed (Mon	th, Day, Year)
N		1 (/2	500		D(0052242		Aug	ust 5,	2004
10		30. Name and address of person who				#210 B :		1	L 100 0	0.679
Sta	ato.	Joseph J. Barth, 31. Date filed (Month, Day, Year)	111, MD 1.		1	#310, Pri	nce Free	ieric.	K MD 2	υ 0/ 8
Sta Registr		AUG 1 0 200	14 Junes		Louis					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

E KANDALI	1- For Unpend Item #23a,pt.II,27,2	Department of Health and Ba-f. per me G835 97970 Certificate of Death	Mental Hygiene Reg. No. 0 0 4	25154
Physician	1. Decedent's Name (First, Middle, Last)	dall	2. Date of Death Month Day Year	4.4
/Medica Examine	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	August 06, 2004	
	3522 Edmondson Avenue	Baltimore		
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.		rthplace (State or Foreign country)
show	Usual Residence of Decedent 10a. State 10b. County 10c. City, 7	Town or Location	<u> </u>	10d. Inside City Limits
should be filed within 72 hours after death with the Maryland nd Mental Hygiene. It marked other then "netural" or Items 23e or 28e-f show umelic event. It e Medical Exercit or matche notified at To Re Completed by Eumarai Director.	Manyland 10e. Street and Number	Tolkmo	10g. Citizen of What C	1 Yes 2 No
23e or ual bar	3522 Edmondson A	2/229	Tog. Citizen of what C	A
al', or items 23e or 28e-f shor Exercinet must be notified at		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- to Rican, etc.) 14. Race - Am Black, Wh Specify: A	
"netur	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	16b. Kind of Business	s/Industry
her th		Usabled 19 Marked - Cina Middle Maide Comman		
r and Mental Hygiene.	1/-		me (First, Middle, Maiden Sumame)	
th and Mer 7 Is marke treumetic	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State,	Zip Code)
item 27 l	Krman Kandall-faller	3710 Flowerton R	d. Breto. md.	21229
or of	1 Surial 2 Cremation 3 Removal from State	e of Disposition (Name of elery, crematory or other place)	Date 20c. Location - City or	r Town, State
Department of Importent: If i any injury or once.	21. Secature of Funeral Service Licensee	22 Name and Address of Facility	507 Arbulus	mq.
Deparement of the control of the con	Mancy m. wallace	- Mancam. wall	are Tune close	V. Baltoma
· ·	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
/sician ledical	Immediate Cause (Final disease or condition resulting in death) Heroin intoxi			Onset and Death
miner	Due to (or as a consequer	ice of):		
= 2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ice of):		
in and rial-transit	If any, leading to immediate cause. Enter Underlying Cause (Disease of reful) that initiated events resulting in death) Last			
	Due to (or as a consequent	ce or):		
the tries	d			
detached for use as detached for use as Dhysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 Ectopic pregnancy	23d. Date of de Month	olivery Day Year
igned by be deta	Part II. Other significant conditions contributing to death but not resulting		23e. Did tobacco use contribute t	o the cause of death?
should b	Cocaine Use, Hypertensive Atheros	clerotic Cardiovascul	ar 1 Yes 2 No 3 P	robably 4 Unknown
has ge 2	Disease		24a. Was an autopsy performed? 11 Yes 2 \sum No 124b. Were a prior to death?	utopsy findings available completion of cause of s 2 \(\sum \) No
s certificate director, pag	25. Was case referred to medical examiner? 15740s 20 No. Hospital:	Oth -	ath Check onl one	ý.
Ë = ⊢	X 163 2 100 I Inpatient 2 EH	Doubted 28c. Injury at Work?	lome 5 Residence 6 Other (Spe 28d. Describe how injury occurred	ocity) SCENE
ctor: After y the funer	2 Accident investigation 8/6/04	Work? 3:00 AM 1 Yes 2X No	Unknown	
completely filled in by the funers	3 ☐ Suicide 4 ☐ Homicide 6 X Could not be determined 28e. Place of Injury - At home building, etc. (Specify) Found at home		28f. Location (Street and 3522 of E City or Town, State) 3522 of E Baltimore, Md	diliondison [,] Ave
he Funeral Director. pletely filled in by the	29a. Certifler (Check only one) Certifying Physician: To the best of my knowle of the properties of examination and manner stated.	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as rred at the time, date and place, and due	s stated. e to the cause(s)
To the complet	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	th, Day, Year)
	letto dron in tall	O.C.M.E.	August 07,	2004
	30 Name and address of person who completed cause of death (Item 23	Ba) (Type, Print)		
	31. Date filed (Month, Day, Year) 32. Registrar's Signatur.	111 Penn Street, Bal	timore, Maryland 2	1201
State Registrar	ALIG 1 0 2000			

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Mi	aryland		rtificate of	f Death	nemai my	Reg No 1	L 5	95155
	Physicia	1	1. Decedent's Name (First, Middle, La: PATRICIA L						2. Dete of De Month	Dey	Year 2004	3. Time of Death 5:30 pm
	/Medica Examine		4a Fecility Name (If not institution, giv. FOREST GLEN I	street end number)		E		4b. City, Town, or L SILVER	ocation of Dear	th 4c. Count	y of Death	OMERY
	Funeral Director		294-40-8718	ex 7. Ag □M 2【XF	ge (In yrs. la 59	st birthdey, Yrs.	If Under 1 Yea Months Days		8. Date of Bi	rth 7 ^y , Ye 1 '945		place (State or Foreign http://listrict Columbia
	ehow		Usuel Residence of Decedent 10a. State 10b. County District		10c. City,	Town or L	ocation				1	Od. Inside City Limits
	the Maryle 28e-f ehor	2 ⊢	District Di Columbia N/A 10e. Street end Number				Washin	ngton, DC				1 ☐ Yes Ž∏ No
	th with	2	3403 Mt. Pl	easant Str	reet 1	NW.		0010		10g. Citizen of	USA	itry ?
960	urs a	Dy rur	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Morrored	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕅 If Yes, Give Year or Dates:		1	Was Decedent of If Yes, specify Cu	Hispenic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ice - Americ ack, White, ity: Whi	etc.
1215-0036	within 72 h	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5	5+)	(Give life.		e during most of work red)		16b. Kind of E		
d 21	al Hygle other t	3	17. Father's Neme (First, Middle, Last)			AIICIC	que Jewe.	lry Dealer			que S	hows
/ian	Mental Mental Irrked o	0 0	Arthur Symeon	Hyman	Anne Gammerman							
Maryland	2 sho end N is ma		19a. Informant's Name/Relationship (1	Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta							,
	s 1 and 2 should be filed f Heelth end Mental Hyg tem 27 is marked othe other traumatic event,	-	Jason Yasner/son 20a. Method of Disposition		20b. Pla	ICE UI DISU	JSILIUTI MAMME UM	easant Str	eet NW	Washing 20c. Location	ton,	DC 20010
Baitimore,	nit. Pages sertment of ortant: if It Injury or o		1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Cei	netery, creson $\operatorname{Cr}\epsilon$	ematory,	Inc. 8	/7/04	Baltim	ore,	MD
Bai	Deper Impor		21. Signature of Funeral Service Licen Dawn F. McDo	nald mold		2	2. Name end Add Cremati 299 Fre	ress of Facility Lon Societ Ederick Ro	y of Ma ad Bal	ryland, timore.	Inc. MD 2	1228
	Physician		23a. Part1. Enter the diseese, or comp shock, or heart failure. List only	blicetions that caused one cause on each lin	d the death. ne.	Do not en	ter the mode of dy	ying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
4	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Conge	25+16	ic He	art fa	ilare wit	h Cara	diomyo	outhy	unknown
		5		Carre	Due to (or	as e conse	quence of):	1 20000	Ca	` ,	2	
	physicien end s the buriel-transit	Examine	Sequentially list conditions,	b	Due to (or	es a conse	quence of):	1 Diseas				conkrown
,09			Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	c. Dro	abet	es	Mellit	us				unknown
68760,		3	resulting in death) Last		Due to (or a							
Box	th cert lending r use			d	lyper	-lews	ion				- 1	unk nown
_	the aff	200	Part II. Other significent conditions co					iven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?
s, P.O.	requires thet the een signed by the hould be detache	2	Osteomyel	+1'S 0+	^ (R)	100	F		10	Yes 2□ No	3 Prot	bably 4 🗖 Unknown
Records,	200	חופופת	OSteomyel altered	menta	1/5	fati	15		24a. Wes	en autopsy ormed?	ava	ere eutopsy findings allable prior to mpletion of cause death?
E. B.	Physician: The law this certificate has rel director, pege 2	5	anem	ia					1 🗆	Yes 2 No	1 [☐Yes 2☐ No
Vita	Physician: this certific rel director,		25. Was case referred to medical examiner?	Hospitel:			_ 0	26. Place of Deat				
Division of Vital	iding Physic th. : After this confunctions of funeral directions.		1 Yes 2 No 27. Manner of Death 1 2 Naturel 5 Pending 2 Accident investigetion	28a. Date of Inju		R/Outpatie 28b. Time o Injury	f 28c. Inj	ther: 4 Nursing Hoursing Hours at ork?	ome 5 Resi 28d Describe	idence 6 □Oti how injury occu	ner (Specify rred	/)
Divis	To the Hospital or Attending PP within 24 hours after deeth. To the Funerel Director: After th completely filled in by the funerel		3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubulding, etc	ury - At hon c. (Specify)	ne, farm, st	reet, factory, office	9	28f. Location (City or To	Street and Num wn, State)	ber or Rura	l Route Number,
	e Hospit 24 hour Funeral stely fills	Zalca!	29a. Certifier (Check only one) 1 Certifying Physics 2 Medical Example 2	vsicien: To the best of iner: On the basis of end menner ste	f examinatio	ledge, deat on end/or in	h occurred at the t vestigation, in my	time, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
	withir comp		29b. Signature and title of certifier	,	·			nse number		29d. Date signe		
)			30. Neme end address of person who	y,mo			D4	3/2/		08/	07/2	2004
	-		30. Neme end address of person who of NURUL CHOWD 31. Dete filed (Month, Day, Year) 20	completed cause of d HURYM	leeth (Item 2 D / ら	23e) (Type,	KING C	CHARLES	WAY;	BETHE	ESDA	, MD 20814
	State Registra		31. Dete filed (Magth, Day, Year) 20	04 32 Registre	er's Signat	Kin Jan	246					

DHMH 16 Rev 6/95

ORIGINAL

			For	State of Man	yland / D	epartme	nt of Health	and Me	ntal Hygi	ene	
			1 = State Registrar		(Certifica	te of Deat	h	Reg	g. No.2	25156
	Physici	an	Decedent's Name (First, Middle, Last)	1 8.	1+1	ر ۵ ه	: O =		Date of Death Month	Day Year	3. Time of Death
3	/Medic		4a. Facility Name (If not institution, give st	ree and number) (1	7556	4b. Cip	Nown, or Locatio		wa	4c. County of Deet	
			Howard Cou	utz Posa	L 08	-0 C	olumb	ia M	4	Kon	iver
	Funeral Director		5. Social Security Number 6. Sex 123 145	M 2□ F 7. Age (/	n yr s. last birth 87 Y	(day) If Und Month:		ler 24 Hrs. 8. s Min. Δ	Date of Birth (Month, Day, 1) PR 14.	9. Birti <i>Co</i>	nplece (State or Foreign untry) 11inois
			Usual Residence of Decedent	1				1 123	un 14,	1011	
	Maryla f show	ō	Maryland Howard	"	0c. City, Town		idge				10d. Inside City Limits 1 ☐ Yes 2 ▼No
	or 28a-	Director	10e. Street and Number				Lip Code		10	g. Citizen of What Co	untry?
	ours after death with the Marylar ral', or itams 23a or 28a-f show Examiner must be notified at		7724 Patuxent Oak				21075			USA	
10	ter de	Funerai	11. Marital Status 1 Never Married 2 Married	 Was Decedent Eve Armed Forces? 14 Yes 2 ☐ No 	er in U.S.		edent of Hispanic (ecify Cuban, Mexic	Origin? (Specify can, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ame Black, White	e, etc.
9036	hours after death with the Maryland lural', or Itams 23a or 28a-f show at Examinat he notified at	þ	3₹ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	WWII	1 🗆 Yes	2X No Speci	ify: 		Specify:	White
15-(72 rear	Completed	15. Decedent's Educ (Specify only highest grade	completed)	1 (Decedent's Us Give kind of v life. DO NOT	ual Occupation vork done during m use retired)	ost of working	11	6b. Kind of Business/	ndustry
212	d within giene.	Som	Elementary/Secondary (0-12)	College (1-4or 5+)		_	pe Opera	tor		Newspa	per
Maryland 21215-0036	wiid be filed Mental Hygi arked other atic event, I	Be	17. Father's Name (First, Middle, Last) William Rutledge	<u>,</u>				ther's Name <i>(F</i> Bess Le		aiden Sumame)	
aryl	should by and Menta is marked sumatic ex	2	19a. Informant's Name/Relationship (Typ		19b.	Mailing Addre				City or Town, State, 2	ip Code)
	# 17 B G		Donna Lynn Evans/d				xent Oak			lge, MD 210	
Jore	of of or		20a. Method of Disposition 1 ☐ Burial 2√☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		-	, crematory or	other place)	8/7/0	-	Oc. Location - City or	
Baltimore,	permit. Pag Department Important: I any injury o		*4 □Donation 5 □ Other (Specify) 21. Signature of unitral Service License	7	Metro	Cremat 22. Name	ory, Inc	L		Baltimore	≥, MD
ä	Per Imp any		Bawn F McI	Omwe/		299 F	tion Soci rederick	iety of Road	Maryla Baltimo	and, Inc.	228
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the	e death. Do n	enter the m	ode of dying, such	as cardiac or re	spiratory arres	st,	Approximate Interval Between set and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a.	Due to for a la c	onsequence of	Ron	pne	umo	MICO	- 4	Low
	Examiner		Sequentially list conditions. b.	del	men	tra					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or s a c	onsequence of):)					
o,	be executed sician and burial-transit		that initiated events c. resulting in death) Last	Due to (or as a c	onsequence of):					
68760	9 × 9	dicai	d.								
Box 6	eath certificat attending phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of						23d. Date of deli	very
	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as if	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tirr 9 ☐ Unknown		3 ☐ Ectopic 5 ☐ Other (Month	Day Year
P.0	that the de led by the a detached i		9 ☐ Unknown Part II. Other significant conditions conf		tot resulting in	the Orio	ca s	ei.	23e. Did toba	acco use contribute to	the cause of death?
Records,	quires n sign	ed by	1/10	reted	- Ju	للك	au	1	1 🗆 Yes	2 □ No 3 □ Pro	obably 44 Unknown
eco	taw require as been si 2 should t	Completed							24a. Was an autopsy		topsy findings available ompletion of cause of
al R		_							perfórme 1 ☐ Yes 21	ed2 death?	2 □ N 0
Vital	Physician: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outs	patient 3 🗆 [Other	ace of Death (C Nursing Home) nce 6 ⊡Other (Spec	:ifv)
n of	fter fter	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Ti		28c. Injury at Work?	28d		v injury occurred	//
Division	Attending or death. ector: After by the fune	licati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home fare	M street facto	1 Tyes 2		Location /Stre	eet and Number or Ru	ral Route Number
οį	s after s after al Dire	Certification:	4 Homicide determined	building, etc. (Specify)	., 50,550, 1250	, y, omoo		City or Town,	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier Certifying Phys	er: On the basis of ex	ramination and	death occurre /or investigation	d at the time, date on, in my opinion, d	and place, and leath occurred :	due to the cau	use(s) and manner as te and place, and due	stated. to the cause(s)
	ro the vithin 2 ro the comple	Med	29b. Signature and title of certifier	and manner stated	J.	2	9c. License numbe	er e	290	d. Date signed (Month	n, Day, Year)
•				MALL	Va		02	192	8 (lug 6+	2004
	it		30. Name and address of person who cor	mpleted cause of deal	th (Item 23a) (1	Type, Print)	+ 341	139 Sit	Sol.	1 P	SPIATO
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	101		, , , ,	J. WIN	-1 and	-INGTRICAS
	Registr	rar	AHC 1 0 2004	74	Ro	1	_				

Certification: filled in by 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical mpletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 118 30. Name and address of person who completed cause of death (Ilem 23a) (Type, Print) 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, TIMONIUM MDRegistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 0 2004 Registrar

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AUGUST

RAIDT, BERTHA

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** August 9.43 PM cobinson 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth Worth Day, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "naturel", or Items 23s or 28s-f show traumatic event, the Modical Examinar must be natified at Baltimore 1 Yes 2 No Funeral Director WD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2120 Peges 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Ampd Forces? Race - American Indian Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Caban, Mexican, Puerto Rican, etc.) t Ves 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+ Manager 18. Mother's Name (First, Middle, Maiden Sumame) 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rung Route Number, City or Town, State, Zip Code) Item 27 ma20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of important: If it any injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State oodlawn Battimore * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Voughn C Greene Funeral Six 21. Signature of Funeral Service Licensee 8728 Liberty Road Randallstown, NID 21133 23a. Part1. Enter the disea e, or complications that caused the shock, or heart failure List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Embolism Physician rulmonay 40min /Medical resulting in death) Due to (or as a consequence of): Examiner HyperKalemia hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner thrombosis To the Hospital or Attanding Physician: The law requires that the death certificate be executed)ee attending physicien and for use as the burial-tran Due to (or as a conseque rice of) Division of Vital Records, P.O. Box 68760, failure Physician/Medical ears IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No cate has been sig., page 2 should b 1 🗌 Yes 3 Probably 4 DUnknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 10 No 1 Yes 2 No 1 Yes Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury · Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 38946B12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Baltimore MD 21218 20 MIVe Parkway Swami Grade Registrar's Signature 31. Date filed (Month, Day, Year) 32 State AUG 1 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State	of Marylan		artment of H		Mental Hyg	iene .g. N.C. () (11.	25150
			Registrar 1. Decedent's Name (First, Middle,	Last)					2. Date of Deat	th	Tells.	3. Time of Death
	Physicia		LaRue Margare	t Rodger	'S				August	Day 8	Year 2004	11:37P. ^M
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	Location of Deat	h	4c. Count	y of Death	
	LXdiiiii	٠.	Carroll County	Medical	Center		Westmin	ster		Ca	rroll	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp	place (State or Foreign ntry)
	Director		213-16-3057	ILIM ZML	83	Yrs.			Feb. 10	,1921	Mar	yland
and	*		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
Maryi	els a	ō	Maryland Balti	more		Catons	ville					1 ☐ Yes 2X No
the !	28a-	Directo	10e. Street and Number	·more		outono	10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
with	3a o	Ö	1003 Kent Aven	nie.			21	228		U.S.	Α.	
death	ms 2	Funeral	11. Marital Status		cedent Ever in U	I.S. 13.	Was Decedent of H		Specify Yes or No- to Rican, etc.)		ce - Ameri	
after	or its	E.	1 Never Married 2 Marrie		2 🔼 No		1 ☐ Yes 2X No				^{ify:} Whit	
Super	ural',	d by	3 ∰Widowed 4 □ Divorced	Year or	Dates:	165 Dans	danda Haval Occur	ation		16b. Kind of		
727	nat.	lete	15. Decedent (Specify only highes		1)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Killu oli	Dusiiiessyiii	dustry
with i	ena. than	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Home	emaker			Ow	n Hom	e
Z Pell	Hygi othar ant, I	a l	17. Father's Name (First, Middle, L	_ast)		1 220		18. Mother's Na	me (First, Middle, I	Maiden Suma	me)	
IT I I I I I I I I I I I I I I I I I I	fental rkad tic av	To B	Otto Obst					Margare	et Mae Ki	rk		
Short Short	s ma		19a. Informant's Name/Relationsh	nip (Type, Print)					ural Route Number			
y M	artre		Melanie Haines	(Daught				Drive We	stminste			
	of He or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation	3 □Removal from	1 .	Place of Dispo cemetery, crei	sition (Name of matory or other pla			20c. Location		
Eag Pag	ment tant: jury o		`4 □ Donation 5 □ Other (Sp	pecify)	Wo		Cemetery	-				aryland
Dantimo	Department of Health and Mental Hygiena. Important: if item 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Extensive must be notified at once.		21. Signature of Funeral Service	icensee	MOU 809		Witzke Fu 630 Edmor	ineral Ho dson Ave	ome of Ca Catonsv	tonsvi ille, l	lle, Maryl	Inc. and 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the dea	th. Do not en	ter the mode of dyin	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition		RDIAC	· ARB	PEST					70 hvs
	/Medical		resulting in death)		o (or as a conse		20 01					70 /
E	xaminer	l.	Sequentially list conditions,	b. HE	ART A	FITAC	K					10 hrs
7	si is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duet	o (or as a conse	quence oi):						70 600
be avecuted	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due t	o (or as a conse	quence of):	UKE				-	70 775
מין פּ	hysician and the burial-transit	calE		6	(B)	FEDI	NG					70 hrs
. BOX 68/	p phys	g		u						- 34		
X o	attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome of pregressions birth 2 Test		□Ectopic pregnanc	v			ate of deliv	
ָהַ הַ	de atte	icia	in the past 12 months? 1 □ Yes 2 ➡ No		gnant at time of		Other (specify)	,		^	Month	Day Year
J B	by the a	hys	9 🗆 Unknown			-			an Bida			the course of death?
S,	ine law requiles that ate has been signed b page 2 should be deta	by	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	inderlying cause gr	/en in Paπ I.	23e. Did to			the cause of death?
ecords,	pinon	ted										
မ် မ	nas b e 2 sl	Completed							24a. Was a autop: perfor	SV /	prior to co death?	opsy findings available ompletion of cause of
		S							1 Tes	2 H 0	1 🗌 Yes	2 No
Vital	or Attending Physician. In the death. Diractor: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	1	7500	Otto	200	eath (Check only or Home 5 TResid		that (Case	
ō	rthis raldi	1: To	1 Yes 2 No	28a. Da	te of Injury	ER/Outpatie	of 28c. Inju	ry at	28d. Describe h		1-1	197
0	th. : After t	to the	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	g (M	onth, Day, Year)	Injury	M 1	rk?]Yes 2 □No				
Division	Attenter death ractor:	ifica	3 Suicide 6 Could determ	inod 206, F16	ice of Injury - At I	home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Nur	nber or Rui	ral Route Number,
á	_ 10	Certification:	4 🗆 Holliicide	Bu	ilding, etc. (Spec	ary)			Only of You	, 0.0.07		
	To the Hospital or Attentivition 24 hours after death To the Funaral Director: completely filled in by the	Medical (Examiner: On the					ce, and due to the courred at the time, o			
	o thi vithin o the omple	Me	29b. Signature and this of certifie				29c. Licen			29d. Date sigi		
,	->-0		1	1			DO	06145	8	08/0	9/20	104
	N,		30. Name and address of person	who completed ca	ause of death (Ite	em 23a) (Type	, Print)		NESTMIN			
	/		TING Li, M	D 410	MALCO	LM D	R Sur	TE A L	UESTMIN	STER	MO	21157
		ate	31. Date filed (Month, Day, Year)		. Registrar's Sign		long	è				
	Regist	trar	AUG 1 0	2004	Beneva	1	South	21				

DHMH 17 Rev 1/2001

LAPLUE MARCHRET RODGERS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 3.30 PM AUGUST 2004 Gladys Ε. Reames Q. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL BALTIMORE MARYLAND ST AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/27/1925 Birthplace (State or Foreign Country) Hours Days 1 ☐ M 2 1 F Yrs. 79 307-20-4366 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Catonsville MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Otto Braun Rosina Bolesch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Maiden Choice Lane Baltimore, MD 21228 Aaron Reames/Husbsnd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Balto-Wash Crematory 08/16/2004 Laurel. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, 736 Edmondson Ave. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a BOWEL NOITSUSTESSO untrowa Due to (or as a consequence of): ENDSTAGE DISEASE KIDNEY Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DIABETES Due to (or as a consequence of): SEPSIS IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy 1 ZYes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

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Funeral

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Completed

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within 72 hours after

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permit. Pages 1 and 2...
Department of Health at Importent: If item 27 is any injury or other treu

Maryland 21215-0036

Baltimore,

burial-transit attending physician Physician/Medical signed by the a à Completed Be ျှ After 1 Certification: To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After

Division of Vital Records, P.O. Box 68760

6/ladys

LEAMES,

Part II. Other s	significant conditio	ns contributing to d	eath but not resu	ılting in the under	lying cause give	n in Part

	25.		case	referred	to	medical
				2 🔼 No		
1	27.	Manr	ner of	Death		

1 Natural
2 ☐ Accident

3 ☐ Suicide

(Check only

29a. Certifier

Medical

5 Pending investigation

6 □ Could not be

1 k Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AUGUST

one) 29b. Signature and title of certifier

29c. License number 17603

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE BETEK DONNEZ 500 CATON

BALTIMORE, MD

04,2004

State Registrar

completely

31. Date filed (Month, Day, Year)



		_	For State Registrar	tate of Marylar		irtment of F <i>tificate of</i>			giene Reg. No2 / 1 () .	OFICE
			Decedent's Name (First, Middle, Last)			·		2. Date of De.	ath	 	3. Time of Death
	Physici /Medic		Catherine Rubin					August	3 200	Yeer 04	6:10 A.M
}	Examin		4a. Fecility Name (If not institution, give street	et and number)		4b. City, Town, o	r Location of Dea	th	4c. County	of Death	
			Manresa Nursing Ho			Annapo				Arur	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) 1922	9. Birthpla Countr MD	ce (State or Foreign y)
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	with with be or	ā					0.1		US		y :
	death ms 23	era	85 Manresa Drive	Was Decedent Ever in U	J.S. 13. V	214 Vas Decedent of H		Specify Yes or No rto Rican, etc.)		· Americe	n Indian,
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. In the matural, or Itams 23a or 28a-f show svent, the Medical Examiner must be notified at svent, the Medical Examiner must be notified at	Completed by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Yes, specify Cub	an, Mexican, Pue Specify:	rto Rican, etc.)	Specify:	k, White, et	c. nite
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Baltimore,	permit. Pages 1 am Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	l OI				chwab Fu			
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O.		Physician/Me	1 \ Yos 2 \ \ \ Yos	4□ Pregnant at time of ⊲ 9□ Unknown	death 5∟	Other (specify)					,
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Division	or At or At or Olive or Direct	Certification:	4 Homicide determined	8e. Place of Injury - At h building, etc. (Speci	nome, farm, stre ify)	et, factory, office		28f. Location (S City or Ton	Street and Numbe m, State)	r or Rural F	Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier Certifying Physicia	an: To the best of my kn	Owledge death	Occurred at the tir	ne date and place	e and due to the	rauso(c) and m	nor se stri	ad
	8 Hos 24 h Fur etely	edical	(Check only 2 Medical Examinar: one)	On the basis of examinand manner stated.	ation and/or inv	estigation, in my o	pinion, death occ	surred at the time,	date and place, ar	nd due to th	ne cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1		29c. Licens	e number		29d. Date signed	(Month, Da	ry, Year)
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	10		30. Name and address of person who comp	leted cause of death (Ite	23a) (Type, I	Print)	1,	11- 6	10	1, ,	17/200
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		-	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			iene eg. Nø? ()	104	25162
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	land II	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
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	or 288	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Coun	itry?
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36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	°	1□Yes 2∏ No	Specify:		Spe	ecity: wh	ite
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	Registra		AUG 1 0 2004	Deres	Po Age	varis					

			_ For	State of Mar	yland / Dep	artment of I	Health and M	lental Hyg	jiene	gible.	05160
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			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	th Day	Yeer	3. Time of Death
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	hislam		shock, or heart lailure. List only Immediate Cause (Final	one cause on each line		2000				16	Interval Between Onset and Death
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2	s bec	Completed						24a. Was a	ın 2	4b. Were auto	psy findings available
ב ז	te ha	E						autops perfor	med? 20 No	death?	mpletion of cause of
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	To the nospital or Attending Frystoan. The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 X Cartifying P	hysician: To the best of miner: On the basis of e	my knowledge, dea	th occurred at the t	ime, date and place,	and due to the c	ause(s) and	d manner as st	ated.
	n 24 in 24 he F	edical	one)	and manner state	ed.	y	opinion, degin occur				
,	To the most	Σ	29b. Signature and title of certifier	//		29c. Licen	se number	2	9d. Date si	igned (Month,	Day, Year)
	σ .		14/h-	1			45475) (0/04	
	10		30. Name and address of person who						1	V	
			Dr. M. R. Rahnam		2 Harford	Road Ba	ltimore, M	Maryland	2123	4	
	Sta	ate	31. Date liled (Month, Day, Year)	32. Registrar	's Signature	Source.	1				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Aug 6, 2004 Year **Physician** Gordon Still, Sr. 4;30A M Lewis /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 608 Baltimore Ave Apt 20 Ocean City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 2, 1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. XXM 2□F Washington DC 72 Yrs. Director 577 44 1025 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 277 No Clinton Directo Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 6607 Woodley Road United States filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XXXo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Barber Self Employed and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental I Joseph Still Nellie Hattcher .. Pages 1 and 2 should be tment of Health and Menta tent: If item 27 Is marked jury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) Mary E. Still (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6607 Woodley Road, Clinton, Maryland 20735 20b. Place of Disposition (Name of cometery, crematory or other place) Aug 10, 2004 20a. Method of Disposition
1 ★ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State permit. Page Department o Importent: If any injury or once. Suitland, Maryland Washington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Suneral Service Litenses 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandira Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ongestive **Physician** years Heart /Medical Due to (or a consequence of): **Examiner** Yocarrid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed orono Due to (or as a cons of ence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tailure 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has autopsy 1 Yes 2 No Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ၉ 1 ☐ Yes 2X ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 💹 X ther (Specify) 2 ER/Outpatient 3□ DOA Rental Apt. the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred of or Attending Patter death. After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide To the Hospital within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely (Check only one) 29b. Signature and (tle of certifie 29c. License number 29d. Datersigned (Month, Day, Year) 9/04 D0042707 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George B. Bren, M.D. 3600 Leonardtown Road #103, Waldorf, Maryland 20601 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State AUG 1 0 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2004 Arthur Edward Spaulding August 9:15am м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F Director 009-05-8389 83 11-16-1920 Vermont Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Maritical Exprise Investigated an once. 1 ☐ Yes 2 No Directo Florida N/A Sun City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2421 Emerald Lake Dr. #203 33573 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No IV es, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Education Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard K. Spaulding Mary Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelley Johnson 9 Kline Blvd Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto. Wash. Crematory 08/11/2004 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityLoring Byers Funeral Directors Inc 8728 Liberty Road Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Arthritis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy performed: 1 ☐ Yes 2 ☐ No 2X No certifi 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 **X** es 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3X DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident the I Director: d in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35164 August 8, 2004 Name and address of person who completed cluse of death (Item 23a) (Type, Print)

Andrew Zarick, Jr, M.D., 15 West Seventh Street, Frederick, Maryland 21701 31. Date filed (A) 10 Pal. 10 2004 32 Registrar's Signature State Registrar

		•	For State Registrar	State	of Marylan			nt of He te of E		nd Me		giene Reg. No. ()	LOL	25166
	20		1. Decedent's Name (First, Mid	dle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
п	Physici		Dennis	Allen	Ste	evensor	1			I	lugust		2004	9:00 a M
	/Medic Examin		4a. Facility Name (If not institut					Town, or	Location of	Death		4c. County of Dea		
	LAGIIII	iei	4 Cinder Roa	đ				Timor	ium			Ba	1timor	e
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under 2	4 Hrs.	8. Date of Birt (Month, Da	h Voarl	9. Birth	place (State or Foreign
	Director		216-78-0599	1 □ M 2 □ F	44	Yrs.	Months	Days	Hours	Min.	Dec 16	, 1959	Mar	yland
			Usual Residence of Decedent											
	yland		10a. State 10b. Cour	ity	10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mar Mar	ţō	Maryland Bal	timore		Ti	moni	um						1 □ Yes 2X No
	the 28a	e l	10e. Street and Number				10f. Zi	p Code				10g. Citizen	of What Cou	ntry?
	3a or	<u> </u>	4 Cinder Road					2109	3			Ţ	JSA	
	leath	Funerai Director	11. Marital Status	12. Was De	cedent Ever in U.	.S. 13. \	Was Dece	dent of His	panic Orig	in? (Spec	ify Yes or No	14.	Race - Ameri	
	ter o	들	1 ☐ Never Married 2 🔀 M	Armed F arried 1 ☐ Yes	2 X No	'	t Yes, spe	ocity Cubar	i, Mexican,	, Puerto H	lican, etc.)		Black, White,	. etc.
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21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show fre Madical Examinat must be notified at	ted	15. Deced	ent's Education		16a. Deced	dent's Usu	al Occupa	tion	of workin	_	16b. Kind	of Business/Ir	ndustry
15	in 7	Completed	(Specify only high Elementary/Secondary (0-12	hest grade completed	(1-4or 5+)	life. l	DO NOT	use retired)	uring most	OI WOLKIN	g			
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	Hyg ethe	BeC	17. Father's Name (First, Midd	le, Last)					18. Mother	r's Name	(First, Middle,	Maiden Sui	тате)	
<u>a</u>	ld be ental ked Ic ev	To B	Herbert H	Russell	Stevens	on, Jr			Pat	rici	а	Byr	nes	
Maryland	2 should be filed within 7 and Mental Hygiene. Tis marked other than "r raumatic event, II e Med	-	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailin	ng Addres	s (Street a	nd Number	r or Rural	Route Numbe	er, City or To	wn, State, Zi	p Code)
Š	Ith a		Mr. & Mrs Hen	bert Steve	enson/Pa	rents	39 (0akwa	y Roa	ıd, T	imoniu	m, Mar	yland	21093
ē,	Hea Hea tem othe		20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of		Da	ate		ion - City or T	own, State
<u></u>	ages int of t: If i		1 XBurial 2 ☐ Crematio 1 4 ☐ Donation 5 ☐ Other		n State	aney V				8/10	/04	Tim	onium.	Maryland
Baltimore	it. Puritme		21 Signature of Fune al Genyi	-/-//	Dul	22	2. Name a	nd Address	s of Facility	/				
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy highly or other traumatic event, Ite Madical Examination must be notified at once.		Bryan W.	Clary	ug) I	Lemmo	n Fur Pado	neral mia	Home Road	of Du Timon	ium,	Valle MD 21	093
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	/Medical Examiner	L		b. T	y PE 1 o (or as a conseq o (or as a conseq	410	BET	R	M	FLU	tus			20 yes.
	ficate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):											
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9	ing pl	Mec	IF FEMALE:											
.O. Box	that the death certificate be executed by the attending physician and detached for use as the burial-tran	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live	outcome of pregna birth 2 Feta gnant at time of d known	ıl death 3□]Ectopic p] Other (s	oregnancy specify)				23d.	. Date of deliv Month	ery Day Year
Ω	requires that the een signed by th nould be detache	'Ph	Part II. Dther significant cond	litions contributing to	death but not res	sulting in the u	nderlying	cause give	n in Part I,		23e. Did to	obacco use	contribute to	the cause of death?
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Vital	of je	Be (25. Was case referred to med examiner?							of Death	(Check only o	ne)		
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Division of	in Sire	Certification:		ald not be ermined 28e. Pla bui	ce of Injury - At h Iding, etc. (Special	ome, farm, str fy)	reet, facto	ry, office		2	8f. Location (S City or Tov		umber or Rur	al Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medicai (29a. Certifier 1 Certi (Check only 2 Medic	lying Physician: To t cal Examinar: On the and ma	he best of my kno basis of examina anner stated.	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	e, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) and date and pla	d manner as a	stated. to the cause(s)
	To the within 2 To the comple	M	29b Signature and title of cer	figr () A			29	c. License		10-		29d. Date si	igned (Month,	Day, Year)
			(thus	A. Doul	~~~)			De	203	to Le	>1	Augus	t 7, 2	004
	1.		30. Name and address of pers	on who completed ca	use of death (Ite	m 23a) (Type.	Print)					<u> </u>	-	
	10		James A. Dic		6701 N.			sı	uite	4105	, Towso	n, MD	2120	4
	- St	ate	31. Date filed (Month Day, Y		Registrar's Sign		- 1							
	Pogiet		AUGI	LUU4 /	The same	15	60	20 1	/					

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Item 22 State of Maryland Department of Health and Mental Hygiene Per FH, G834,08/10/04dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev **Physician** Month Year DMITH MATTIE 4b. City, Town, or Location of Death 2004 4:45 /Medical 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick Villa Nursing Center 711 A Catonsville Baltimore, Md. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 M 2 F 230-20-5673 Yrs. Director May 26, 1918 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 98 1 and 2 should be filed within 72 hours after death with the Maryla of Healith end Mental Hygiene. The Item 27 Is marked other than "naturel", or items 23a or 28a-1 show other traumstic event, its Medical Examinar must be notified as Maryland Baltimore Catonsville Director 1 ☐ Yes 🛠 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 711 Academy Road 21228 USA Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes & ☐ No Specify: Specify: Black δ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th grade Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annie L. Elkerson Ben Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linburg Spencer 3611 Whitehead Rd Keysville, Virginia 23947 20b. Place of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Peges 1 Depertment of H Important: If ther any Injury or ott cemetery, cremetory or other place) 1 □ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 7/31/ cem. 3 □Removal from State Kenbridge, Virginia New Grove Baptist Ch. 22. Name and Address of Facility Chatman-Harris Funeral 21. Signature & Funeral Service Licen; 5240 Reisterstown Rd Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical tmmediate Cause (Final BRONCHO- PNE WMOHIA disease or condition resulting in deeth) Mose have Examiner Due to (or as a consequence of) STROKES ed by the attending physiclen and detached for use as tha burial-transit The law requires that the death certificate be execut Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 HBERTENSION Physician/Medical Due to (or as e consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed b DEMENTIO ģ icata has been sig r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificata funaral diractor, pag 1 Yes 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural daath. ne Hospital or Attendii n 24 hours after daath. ne Funeral Director: A bletely fillad in by tha fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. completely (Check only one) within 2 To the F 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D 30469 st 2nd. 2004

State

DHMH 16 Rev 6/95

State 31. Date filed (Month, Day, Year)
Registrar

32. Registrer's Signature

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1 0 2004

32. Registrer's Signature

ORIGINAL

Ellicott Lity.

Mg, 21042

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PRIVE :

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 10:43 AN Southford Theresa 00 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** University ar If Under 24 Maryland Medical Center N/A 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 21X F Hours Days Months **Director** 5,1974 Maryland Usual Residence of Decedent death with the Maryland show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Glen Burnie Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7979 Covington Ave. 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Phlebotomist <u>Anne Arundel Medical</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Center Be 2 Tracy Diana Collins Α Barry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I 8130 Hog Neck Road Pasadena, Maryland 21122 Diana V. Neice (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Department of H Importent: If Ite any injury or ot once. 1

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/11/04 Glen Haven Mem.Pk. Glen Burnie, Maryland 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses line 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician *braccarcutis* disease or condition resulting in death) 6 weeks /Medical Due to (or as a consequence of): Examiner Ance Sequentially list conditions, any, leading to inthe ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner flooden M. Ki The law requires that the death certificate be executed anding physician and use as the burial-tran-Due to (or as a consequence of): Box 68760. Physiclan/Medical attending p for use as CERTIFICATION APPROVED BY Month Day IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No o. 9 Unknown 9 Unknown an signed by the ۵ Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed cate has been page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy performed? Yes 2:2 No certificate 1 Yes Division of Vital To the Hospital of Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA 2 ihis 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funerel Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled ir by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

phannon

31. Date filed (Month AUG 1") 2004

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, M

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year August 12:30 FM 05,2004 V. Sparra /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 □ F Director Yrs. 218-46-6948 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 is marked other then "naturel", or items 23e or 28e-f shov or other traumatic event, the Medical Examinar must be notified at 1 R Yes 2 No Director N/AMaryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1725 Belt Street 21230 U.S.A. e filed within 72 hours after death all Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ■Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bill Collections Glenn Associates N/Apermit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liviny or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Vivian Jennings Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Sparra (Wife) 1725 Belt Street Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/9/04 Glen Haven Mem. Pk. * 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licensee 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction Days /Medical Due to (or as a consequence of): Examiner Atherosclerotic Coronary Artery Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached t Records, P.O. 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Malignant Lymphoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an autopsy performed? certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 Inpatient ၉ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) rathologist 08-06-04 D 34543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AXE, Osler 76171 Drive Towson, Maryland 21204 31. Date filed (Month, Day, Year) AUG 1 0 2004 32 Registrar's Signature State Registrar

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Box (
P.O.
Records,
Vital
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Division

			State of Maryland / Department of Health and Mental Hygiene
			1- State Registrar Certificate of Death Reg. N6)
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Mid
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death
ľ	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. Thigh 1 Age (In yrs. last birthday) 9. Birthplace (State or Foreign South Caround) 1 Usual Residence of Decedent
	nyland show		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	the Ma 28a-1 e	ecto	109. Street and Number 101. Zip Code 102. Citizen of What Country?
	d within 72 hours after death with the Maryland piene. r than "natural", or itams 23s or 28s-1 show the Middeal Examiner must be multined at	Funeral Director	1239 DARLEY AVE. 21218 U.S.A.
	itams itams	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves. specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
9036	ours at	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: Specify: Specify:
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		Com	Elementary/Secondary (0-12) College (1-4or 5+) JANITORIAL SCHOOL
Maryland	e d ala	To Be	17. Father's Name (First, Middle, Last) TOHNNY STOVER, SR. 18. Mother's Name (First, Middle, Maiden Sumame) TANIE STEVENSON
Mary	s 1 and 2 should t Health and Mer item 27 le marks other traumatic		19a. Informant's Name/Relationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) JANIE MAG JULIUS MOTTER D39 DARKEY NG. BATO, MO 21218
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Ba	permit. Departi Importi any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Valsation C. Celling Funder Home 495 YORK ROPP BATTIMERE, NO 21212
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ŀ	Examiner		Due to (or as a consequence of): BILATERAL PNEUMONIA
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Ó	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. ACUTE ON CHRONIC RENAL FAILURE Due to (or as a consequence of):
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ls, P.	ires that signed k I be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LARYNGEAL CANCER 1 Yes 2 No 3 Probably 4 Dunknown
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Divi	al or Attendin s after death. I Diractor: Af d in by the fur	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Hospite 4 hours Funera	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the complet	Me	29b. Signavire and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
_	(SHILPA D'GAITONDE, SOOI LOCHRAVEN BLVD, BALTIMORE MD 21239
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	D		Usual Residence of Decedent		•			OCL. 2, 1:	
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	r 28a-	Director	MD Baltimore 10e. Street and Number		<u>Lansdowne</u>	10f. Zip Code		10g. C	itizen of What Country?
	ath wit	raiD	518 Carlsbad Cour	t		21227			USA
920	be filed within 72 hours after death with the Maryland stal Hygiene. sd other than "natural", or itama 23a or 28a-f ehow event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:		Was Decedent of Hi fYes, specify Cuba I□Yes 2√2 No	ispanic Origin? (Specin, Mexican, Puerto R Specify: whi	1	14. Race - American Indian, Black, White, etc. Specify: white
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Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	Da Da	te 20c. L	ocation - City or Town, State
<u>Hi</u>	permit. Pages 1 Department of H Important: If Ita any injury or ot		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Light)			Cem Aug.		cel, MD Funeral Home
Ba	Depa Impo any is		KIM LC	Mango	V = 3	620 Wilke	ns Ave. Ba	altimore,	
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rds, P	law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause give	en in Part I.		use contribute to the cause of death?
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Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office	28	f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
	To the Hospital or Al within 24 hours after of To tha Funeral Direc completely filled in by	edicai	29a. Certifier (Check only one) Certifying Physical Example 2 Medical Example 2	rsician: To the best of r iner: On the basis of ex and manner stated	tamination and/or inv	occurred at the tim restigation, in my op	ee, date and place, an binion, death occurred	nd due to the cause(s I at the time, date an	c) and manner as stated. d place, and due to the cause(s)
	To the I within 2 To tha Complet	Σ	29b. Signature and title of certifier	4	M	29c. License			ate signed (Month, Day, Year)
	ń		30. Name and address of person who come the second of the	ompleted cause of deat		fon Ave	enne, Ba	elpinos.	14 30, 2004 MD 21829
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	back			

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			5. Social Security N				lest birthday)		r 1 Year	If Under		Date of Birth			(C4-4 F
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<u>-</u>		F	19a Informant's N	ame/Relationship	(Type Print)		10h Maili	no Address	c (Street :				, City or Town,	State Zin	Code
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Baltimore,	- I E E	Ī	20a. Method of Dis				Place of Dispo			a)		Date	20c. Location -	City or Tov	wn, State
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ă	Den Pen Pen Pen Pen Pen Pen Pen Pen Pen P		21. Signature of E	inald S.	Wade D	recto		tate altim			bard 21201	633 W.	Baltim	ore S	treet
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	The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	Physician/M										1 □ Y	es 2 No	3 Prob	abły 4 □ Unknown
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	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Me	29b. Signature end	title of certifier				290	. License	number		2	9d. Date signe	d (Month, D	Pay, Year)
	, , , , ,			C: . Z -	- 1 -	111			158	96			7/30/0)/	
		-	30. Name end addr	SIGO / W	completed sauce	of death /lte-	n 23e) /Trac	Print)					11		
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£.	Registra		AUG 1		heren	4	1	- //	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

10 DAYS

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

AUGUST 8, 2004

Year

White

1 ☐ Yes 2 No

1245PM

4

within 24 hours a To the Funeral C

State Registrar

Medical

STEPHANIE 32/ Registrar's Signature 31. Date filed (Month, Day, Year) AUG 1 0 2004

6 Could not be determined

UAROCLEJA MO SINAL HOSPITAL OF BALTIMORE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Aes-000

DHMH 17 Rev 1/2001

3 T Suicide

29a. Certifier

4 - Homicide

(Check only one) 29b. Signature and t

30. Name and addess of perso

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Ralph P. Taylor, Sr. 5:00 P M Lock 0.7 OX /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore N/A 8. Date of Birth (Month, Day, Yo Apr. 28, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 215-22-4935 1 € M 2 □ F 78 Director 1926 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or Items 23e or 28e-f show treumatic event, its Medical Exame an inust be invitted at N/A Maryland Baltimore 1√Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Heatth and Mental Hygiene. Ant: If Item 27 is marked other then "natural", or Items 23e or it 1411 Medfield Avenue 21211 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1★Des 2□No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White 3 € Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Turbine Room 12 <u>Gas & Electric Co.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Taylor ပ Kathryn Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Rupp Daughter 4 Brecon Place Cockeysville, Maryland other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 5 2☐Cremation 3 ☐Removal from State 1 X Burial permit. Page Department of Importent: If any injury or Maryland Veterans' 8/11/2004 5 ☐ Other (Specify) Garrison Forest, MD * 4 Donation 22 Name and Address of Facility
Burree-Henss-Seitz Funeral Home, Inc.
3031 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service Licens 23a. Part1. Ent-r/ he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h art failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myelomonocytic levinemie Chlopic unknown /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate case. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Por in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 2 No 1 Yes 2 🔀 No 1 Tes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: ို 1 Yes 2 No 1.₽¶npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dired 29a. Certifier Medical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DSUZG 08,07,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL BALTIMENE, MD Serjamin MO 31. Date filed (Month, AUGI) 0 32. Registrar's Signature 2004 State Registrar

			• -	Mordand / Department of b		_	_	
			State	of Maryland / Department of I Certificate of			No 2004	25175
			Decedent's Name (First, Middle, Last)	Certificate of	Death	2. Date of Death	. No	3. Time of Death
	Physici		WARD IT	CNBSNW		Month 8	Day 2004	1.30AP
1	/Medio Examin		4a. Facility Neme (If not institution, give street and nu	,	4b. City, Town, or Lo		4c. County of Death	
	Lxamii	Ci	Frederick Villa	Nur. Center	Catous	sville MI) Balt	more
	Funeral Director		5. Social Security Number Sex 15M 2DF	7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)
	tand		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
	Marylar I-f show	ţ	W M	A Baltimore				Yes 2□ No
	ith with the Maryla 23a or 28a-f shovest be retified at	irec	10e. Street end Number	10f. Zip Code		100	J. Citizen of What Co	untry?
	ath w	Funeral Director	3125 Winson Blvd.		21201		UD/	
	ter dea items	nue	Armed F		Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
20	urs aff	by F	1 Never Married 2 Married If Yes G 3 Widowed 4 Divorced Year of I	2 □ No ive 1 □ Yes 2 No Dates:	Specify:		Specify: D	100 K
Maryland 21215-0020	72 hours after death with the Maryland netural', or items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed,	16a. Decedent's Usual Occu (Give kind of work done	pation	ing 16	6b. Kind of Business/	ndustry
21	S 1 4	nple.		1-4or 5+) life. DO NOT use retire	ed)	9	10000 au	dala
2	be filed withintal Hygiene. d other then event, the v	S	17. Father's Name (First, Middle, Last)	DUS DK	18 Mother's Name	e (First, Middle, Ma	viden Surname)	rtuation .
and	d be f antal H ed ot	Be	Roy Townsend		Lennie	1 1	ews	
ary	s 1 and 2 should be f Health and Menta tem 27 is marked other traumatic ev	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Stree	t and Number or Rur			(ip Code)
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ore		1	20a. Method of Disposition 1□ Rurial 2 □ Cremation 3 □ Removal from	20b. Place of Disposition (Name of cemetery, crematory or other place)		Date 20	c. Location - City or	Town, State
Ĕ	Page ment c ant: if ury or		4 □ Donation 5 □ Other (Specify)	Garrison forest	· VA . 8	6-16-04 () wings n	nils, MD
Baltimore,	permit. Pag Depertment Important: I any Injury o		21. Signature of Funeral Service Licensee	22. N m and Addr	ess of Facility VQ	ughn c.c	reend Fu	noval Service
_	40 = # Q		May Col	8728 Lu	berzty 20), Kand	allstown	TELLE QUIT
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do not enter the mode of dy each line.	ring, such as cardiac	or#espiratory arres	it,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final	00000000			I	
	Examiner		disease or condition resulting in death) a	Due to (or as a consequence of):			and the state of t	
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760,	te be execut ysician and ie burial-trar	cai E	Cause (Disease or injury C.	DIABETIC N	1= 6HBO	PATHY		
687	tificate ig phys es the	-	that initiated events resulting in death) Last	Due to (or as a consequence of):				
Box	eath certifi ettending I I for use es	Physician/Med	d					
	death e ette ed for	sicia	Part II. Other significant conditions contributing to o	death but not resulting in the underlying cause g	iven in Part I.	23b. Did tob	acco use contribute	to the cause of deeth?
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S,	v requires that been signed t should be det	۵		and a service of the Australia Company of the Compa			7 044	Afora automorphisms
Ö	requi	Completed	DYSPHAGIA			24a. Was an perform	ed?	Were autopsy findings available prior to completion of cause
Rec	The law cate has t page 2 s	ם				4.FD.V	1	of death?
[a]	ician: The certificate rector, pag		25. Was case referred to medical		26 Place of Dea	th (Check only one	1	1 ☐ Yes 2 No
<u> </u>	ystcian: 'is certifica	To Be	examiner?	Inpatient 2 ER/Outpatient 3 DOA	whore 1		nce 6 Other (Spe	cify)
ō	afing Phy h. After thi funeral		27. Manner of Death Natural 5 □ Pending 28a. Date (Mo	e of Injury 28b. Time of 28c. Injury W	ury at ork?	28d. Describe how	v injury occurred	
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certifical or death. or doath. ector: After this certificate has been signed by the ettending phy by the funeral director, page 2 should be detached for use es th	catic	2 Accident investigation	M 1	ŢYes 2□No			
Ξ̈́	or Att fter d Direct in by	rtifi	determined 200. Place	e of Injury - At home, farm, street, factory, office ding, etc. (Specify)	Э	28f. Location (Street) City or Town,	eet and Number or Ri State)	ural Houte Number,
	To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Certification:	29a. Certifier Certifying Physician: To th	e best of my knowledge, death occurred at the	time, date and place.	and due to the car	use(s) and manner as	s stated.
	e Hos 124 h e Fun e Fun	dic	(Check only 2 Medical Examiner: On the	basis of examination end/or investigation, in my nner stated.	opinion, death occur	red et the time, da	te and place, and due	to the cause(s)
	To th To th comp	M	29b. Signature and title of certifier	~	nse number	29	d. Date signed (Mont	h, Day, Year)
	\wedge		Maple	, D d	0303		890	4
	5		30. Name and address of person who completed can	use of death (Item 23a) (Type, Print)	Fredeur	urd ste	8 9 10 162 cet	onsville, MD
			31. Date filed (Month, Day, Year) 32.	Registrar's Signature		•		21228
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				1 - State of Maryland	d / Department of Health and M Certificate of Death	/	2001 05176
				Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. N	3. Time of Death
_		Physici		MARY D.	TRIPP		Pay Year 0658 M
		/Medi Examir		4a. Facility Name (If not in titution, give street and number)	4b. City, Town, or Location of Death		lc. County of Death
	1			STELLA MARIS HOSPICE	E BALTIMO	ORE	NIA
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. It	ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
		Director		Usual Residence of Decedent	Trs.	Aug. 3. 19	33 MARYLAND
		yland			, Town or Location		10d. Inside City Limits
		Mar a-f st	ctor	MARYLAND NIA	BALTIMORE	E CITY	1 XYes 2 No
		ith the	Director	10e. Street and Number	10f. Zip Code	19g. C	Citizen of What Country?
		s 23s	rai	1316 WOODYEAR STREE		7	USA.
		Item	by Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married	S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
	920	urs af	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: BLACK
	21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b.	Kind of Business/Industry
	2	vithin ne. han	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		
7		filed v Hygie other t	S	17. Father's Name (First, Middle, Last)	FACTORY WOR	KER M e (First, Middle, Maide	
R	ano	Mental I Mental I arked of	To Be	JOSEPH STEW		RICE	Bean
MAR	Maryland	2 should be end Mental is marked a	F	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rur		or Town, State, Zip Code)
6		is 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health end Mental Hygiene. tiem 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at		JEROLYN PITTS (DAUGHTER)	7801 DOE RINGED	R. WOOD	LAWN MD. 21244
0	Baltimore,	ges 1 and of the if it if item or oth		20a. Method of Disposition 20b. P		Date 20c.	Location - City or Town, State
1	Ĕ	L and Ba		'4 □ Donation 5 □ Other (Specify)	RRISON FOREST 108-1	2-04 04	UINGS HILLS, MD.
AL	3ali	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility BR	ROWN JR.	FUNERAL HOME
		40 = 4 d	_	23a. Part1. Enter the disease, or complications that caused the death			LTO, MD. 2/2/7
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	н	Examiner			ience oi).		
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Class of Injury	uence of):		
		and I-transi	Examiner	that initiated events c.			
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×	of	Phys er this eral di	1: To	1 Yes 2 No	28b. Time of 28c. Injury at	ome 5 Residence 28d. Describe how in	
	ion	nding I ath. r: After e funer	ation	1 □Matural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury Work? M 1 Yes 2 No		
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	Ö	spital or Attending Phours after death. Incal Director: After the filled in by the funeral					
		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my kno 2 ☐ Medical Examiner: On the basis of examinal and manner stated.	wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
_		To th To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
		^		M PM NE	D40854		8/6/2004
		'h		30. Name and address of person who completed cause of death (Item			1 2
		C+	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signa		more m	rd. (1202
		Regist		AUG 1 0 2004 Sheers	& Sparks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 tugus /Medical 4a. Facility Name (If not institution 4c. County of Death Examiner 4b. City, Town, or Location of Death TOSPICE

7. Age (In yes. last birthday) r If Under 24 Hrs. 6 5. Social Security Number 215 - 30 - 6769
Usual Residence of Decedent Social Security Number 6. Sex If Under 1 Year Months Days 8. Date of Birth **Funeral** Birthplace (State or Foreign Obuntry) Hours 1 ☐ M 2 💢 F Min. Director Yrs filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner out be notified at 10d. Inside City Limits Maryland Completed by Funeral Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rmou 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced "natural" Slac th and Mental Hygiene.

7 Is marked other than "natur traumatic event, the Modest 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be f Department of Health and Mental F Important: If item 27 is marked of ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Ho. Md. 21207 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 Removal from State 8 2004 * 4 ☐ Donation 5 ☐ Other (Specify) arme 21. Signature of Funeral Servide Licensee 22. Name and Address of Facility
Joseph L. Russ Tun.
12222 W. North Ave. Tuneral Home tue. Balto. Md 23a. Part1 Enter the treease, or complications that has a the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immedia e Cause (Final Physician Mangiocarcinoma disease or condition resulting in death) month /Medical Due to (or as a consequence oy: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown atitis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NSO C 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient this (3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 🗌 Accident investigation Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) nin 24 hours after the Funeral Direct 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi The decided of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

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32. Pegistrar's Signature

Kuun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

31. Date filed (Month, Day, Year) AUG 1 0

ANDREW WILLIAMS 04-04809 Unpend item#23a,27, per me, C834, 8/20/04 FITE Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Per FH, C834, 08/10/04dhb
Registrar

Reg. No. 0 1 RKD 1- State of Maryland / Depa 1- State Amend Items 19a,b per FH, G834,08 Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** JULY 24, 2004 Andrew Leon Williams 4:55P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SHOCK TRAUMA CENTER BALTIMORE n/a 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Funeral **X**□M 2□F Months Days Hours Min Yrs. 247-82-4529 Director 54 Sept. 26,1949 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f ehow other traumatic event, the Medical Examiner must be notified at N/ABaltimore 1 √Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 1025 Aisquith Street USA flems 23a 2 should ba filed within 72 hours after death on and Mental Hygiene.
Is marked other than "natural", or flems 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Master Barber <u>12th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Virginia Issaac Willie Williams 19a. Informant's Name/Relationship (Type, Print)

Debra Williams/Sister

Marion Lyde/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 1409 S. 23rd St., Phila Pa 19146 ce of Disposition (Name of Date 20c 20c. Location - City or Town, State 20a. Method of Disposition Memorial Ga7/31/04 ₽ = 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ō permit. Page Department of Important: ff any injury or once. Dundalk, Md 21. Signature of Funeral Se Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** Intracerebral Hemorrhage disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner Dira to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. þ signad I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Compieted by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No Yes 2 🗆 No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1XYes 2∏No 1X Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 Yes 2 No investigation death 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ٥

State Registrar AUG 1 U 2004

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

JULY 25,2004

			1 - For State Registrar	State of Marylan		artment of H			iene	25179
			Decedent's Name (First, Middle, Last)					2. Date of Dear	th	3. Time of Death
	Physici /Medi		Charles Willia	am Whims,	Sr.			July 2	9. 2004	4:00 P.
	Examir		4a. Facility Name (If not institution, give street 4717 Old York Ro			4b. City, Town, or Baltimo	Location of Death		4c. County of Death	h
	Funeral Director			7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) Co.	nplace (State or Foreign untry) Maryland
	and 1		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Maryl f sho	ō	Maryland N/A			imore				1★ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	th wit		1144 Gorsuch Ave	nue		21218	3		USA	
36	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-1 show the Modical Examiner must be notified at	by Funeral	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? 1XYes 2 □ No WW If Yes, Give	2	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐ No	spanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B]	e, etc.
Ö	hour	ed b	3 ₩ Widowed 4 Divorced 15. Decedent's Educat	Year or Dates:	1	dent's Usual Occupa	ation		16b. Kind of Business/I	
15	n "na	plet	(Specify only highest grade c	ompleted)	(Give	kind of work done of DO NOT use retired	furing most of won	king	TOD. KING OF BUSINESSY	noustry
212	11 TO 12 11	Completed	2	Years	Hors	e Traine	er	R	ace Track	
pu	be filed Ital Hygid of other event, II	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, I		
yla	should be ind Menta marked umatic ev	2	Melvin Whims					Mae Qu		
Maryland 21215-0036			19a. Informant's Name/Relationship (Type, George Whims	Print)					City or Town, State, Z e, Maryla	
	of Health of Health Itam 27 i		20a. Method of Disposition	20b. F	Place of Disno	osition (Name of			20c. Location - City or 1	
nor	Pages nent of int; if it		Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	Court from Chata	emetery, cre-	matory or other place	Memoria	/3/04		ı, Marylan
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee		_	_		natman-	Harris Fu	neral Hom
	00200		23a. Pagy. Enter the disease, or complica	ions that caused the deat				В	altimore,	Maryland Approximate
	Physician /Medical Examiner		speck, or hear/failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	ULE		PIVE	or rospitutory and	341	Interval Between Onset and Death 3 muntrs
8760,	sate be executed only sicien and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	Due to (or as a conseq						
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ≧ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	very Day Year
s, P	quires that n signed b uld be deta	by	Part II. Other significant conditions contrib	outing to death but not res	ulting in the u	nderlying cause give	on in Part I.		pacco use contribute to	- 1
Vital Record	The law requir ate has been si page 2 should	ompleted						24a. Was autops perform	y prior to o death?	opsy findings available ompletion of cause of
ita	(0	BeC	25. Was case referred to medical examiner?				26. Place of Dear	th Check on one		2010
of V	g sis	10 T	1 ☐ Yes 2 No Hos	pital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	4 Nursing H	ome 5X Heside	nce 6 Other (Spec	ify)
	al or Attanding Pt i after death. I Diractor: After th d in by the funeral	ation:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at ? (es 2 □ No	28d. Describe ho		
Division	tal or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office		28f. Location (Sti City or Town	reet and Number or Rui , State)	al Route Number,
	To the Hospital or Al within 24 hours after of To tha Funaral Dirac completely filled in by	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examiner	an: To the best of my kno On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2. To tha I complet	Ž	29b. Signature and title of certifier			29c. License	number	29	od. Date signed (Month)	Day, Year)
	1		1/4~	_		D	305/	/	August 2	,04
	- Q		30. Name and address of person who comp	eleted cause of death (Item	23a) (Type,	Print) DANK H	eights,	me Bx	August 2000	21215
ŀ	Sta Registi		31. Date filed (Month, Day, Year) ALIG 1 0 2004	32. Registrar's Signa	ture	als				

Funeral Director 5. Social Security Number 6. Sex 1 M 2 F 87 1 M 3 F 1 M 4 F 1 M 4 F 1 M 5 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M 1 M	7:15 A ^M
Charles H. Weigand August 4, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Retirement Community N/A Balt 5. Social Security Number Director 6. Sex 1 Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day, Year) 87 Usual Residence of Decedent 87 Yrs. Sept. 7, 1916 N	7:15 A M imore rthplace (State or Foreign Jountry) laryland
Charlestown Retirement Community S. Social Security Number T. Age (In yrs. last birthday) The property of t	imore Implace (State or Foreign Jountry) Including 10d. Inside City Limits
Director 215-10-8946 Usual Residence of Decedent 1 M 2 F 87 Yrs. Months Days Hours Min. (Month, Day, Year) Sept. 7, 1916	10d. Inside City Limits
9	
Maryland Baltimore Baltimore 106. Street and Number 109. Citizen of What C	10 Vac 25 No
10e. Street and Number 10f. Zip Code 10g. Citizen of What C	1 1 1 1 1 2 2 2 2 1 1 1 0
\$ 6 1 1 707 M + 1 01 + T	Country?
Fig. 707 Maiden Choice Lane 21228 U.S. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	S.A.
10 Maiden Choice Lane 21228 U.S.	
Specify: Sp	hite
Specify: Specify:	s/industry
College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame)	/t.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	1
Anthony Weigand Helen Spa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,	
	.22
O P = 1 Di Burial 2 Cremation 3 Removal from State	
21. Signature of Fundral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Marylar	nd 21122
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition resulting in death) Amedical Immediate Cause (Final disease or condition resulting in death) Amedical Immediate Cause (Final disease or condition resulting in death)	Onset and Death
Examiner Some 15	Marks
Sequentially list conditions, flarly, leading to immediate cause. Enter Undertying Cause (Disease or injury	WESENS
The state of the s	-
Cause. Enter Underlying Cause (Disease or righty that initiated events resulting in death) Last Due to (or as a consequence of):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 Yes 3 Yes	to the cause of death? Probably 4 Unknown
1 Yes 2 No 3 Yes 2 No 3 Yes 2 No 3 Yes 2 No 3 Yes 2	autopsy findings available o completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No Nursing Home 1 Yes 2 No	pecify)
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1 Accident 5 Pending investigation 5 Pending investigation 5 Pending investigation 5 Pending investigation 6 Could not be determined 6 Could not be determined 6 Could not be determined City or Town, State) 286. Location (Street and Number or City or Town, State) 287. Location (Street and Number or City or Town, State) City or Town, State)	Pura i Boute Mumber
27. Manner of Death 1	nurar rioute rumper,
2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	as stated. ue to the cause(s)
## 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	nth, Day, Year)
Munico D30989 Avoust	4005 40
30. Name and agress of person who completed cause of death (Item 23a) (Type, Print) Myla in Carpentat. No 74 Maidan Choice Ln Co	thought
State Registrar 31. Data/filed (Monty Provider) 2004 32. Registraries of Apocks	JUININ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Leslie White August 03 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Reisterstown Baltimore Future Care Cherrywood If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220-03-5173 Usual Residence of Decedent M 2DF Yrs Director 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No To Be Completed by Funerai Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Ітата 23а Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hyglene. College (1-4or 5+) uto Mechanic Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If itam 27 is any injury or other train once. ot 219, Kandall Stown, MD 200. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cembery, crematory or other place, 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State baltimore ^¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WoughnC Greene Funeral Randallstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate **Physician** with bony Years cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Hospitel or Attending Physician: The law requires that the daath certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) P.O. 1 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be det 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Arterroscleration cardiovascular diseas 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funarel Diractor: A completely filled in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 2004 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

Road 2n 5400 Old Court Road 21133 MD #108 RandallsTown

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG 1 0 2004

32 Registrar's Signature

6036			State of Maryland / Department of Health and N 1 - For Amend Item 1, Unpend Item #23a&27 per me 6834, 8/17 Certificate of Death	lental Hygi	ene	
			- State Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	-	25182
	Physici		SHEDEENA WHITE	Month August	Day Year	3. Time of Death 2:53 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	August	4c. County of Death	
			2719 Spelman Road Apt. Bl Baltimore		N	A
3	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K F 7. Age (In yrs. last birthday) 1 Vrs. Months Days Hours Min.	8. Date of Birth (Month, Day, JUNE 9,	9. Birth Co. 1964 M/	nplace (State or Foreign untry)
4	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Plygiene. Important; If item 27 le marked other then "natural", or Items 23e or 28e-f show eny injury or other treumetic event, If a Medical Examination to other treumetic events and the other events and the other events and the other events and the other events and the other events and the other events and the other events and the other events and the other events and the other events and the other events and the other events are events and the other even	Director	MARYLAND N/A BALTIMORE	CITY		1 ⊠Yes 2 □ No
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Box 6	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	verv
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√ <u>5</u>	law req as beer 2 shou	Completed		24a. Was an	24b. Were aut	opsy findings available
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/ita	vicien: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?			
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	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number		d. Date signed (Month	
	K. f.		Zabinisch Ac. C.C.M.E.	Au	gust 4, 20	U 4
	1 8,00h		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24Bi4Cc44 4Cl 111 Penn Street.	Raltimo	ire	1 00000
	Sta Registr		2ABjuce 44 ALJ 111 Penn Street, 31. Date filed (Month, Day, Year) AUG 1 0 2004 Service Signature Apauls	TALL CHILD	<u>~~•</u> Maryla	na 21201
		•				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Time of Death 5:25PM M 1. Decedent's Name (First, Middle, Last) 2004 **Physician** WEBB July 31 WALTER /Medical 4b. City. Town, or Location of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Univ. of Maryland Medical Syst 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6 Sex Birthplace (State or Foreign Country) Funeral Months **XX**M 2□ F 63 Director 219-38-7207 01/17/1941 MD Usual Residence of Decedent Manyland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylan Depertment of Heelth and Mental Hygiene.
Important: if item 27 is marked other than "natural, or itema 23a or 28a-i show any injury or other traumatic event, the Medical Examination and ited at once. 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 441 S. Bentalou St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ▼ Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Poultry 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Burton Webb Lucille James ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Lee Ziegler/Fiancee 441 S. Bentalou St., Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) **Bayview Crematory** 08/05/2004 Baltimore, MD 22. Name and Address of Facility.

Ambrose Funeral Home, Inc. 1328 Sulphur Spring 21. Signature of Funeral Service Licensee Catherine N. Tolbert perDVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock **Physician** /Medical Due to (or as a consequence of): Examiner 2 weeks Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The lew requires that the death certificate be executed burial-transit Dilated Cardiomypathy Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 🗌 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2X No 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 文No ည 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a **XXcertifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the within 2 and manner stated 29d. Date signed (Month, Day, Year) Aug. 5, 2004 29b. Signature and title of certifier 29c. License number 15870 completed cause of death (Item 23a) (Type Prints t. Balto, Md 21201 30. Name and address of person who Kerri Kissell, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 0 2004 Registrar

		1	For Amend Item 8 per rH, 6545, 077 epartment of Health and Me 1 - State Registrar Certificate of Death	ntal Hygien		25 84
	Physici	an	The state of the s		ay Year 3, 2004	3. Time of Death 9:42 F M
	/Medic Examin		4a. Facility Name (If no institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or Location of Death Towson	4	c. County of Deat Balt	imore
	Funeral Director	•	Months Days Hours Min.	Date of Birth (Month, Day, Yea 2/16/19 3	r) Go	nplace (State or Foreign untry) CAROLINA
	Maryland f show		10a. State 10b. County 10c. City, Town or Location 10d. Timore			10d. Inside City Limits 1 Yes 2 □ No
	with the	Funerai Director	10e. Street and Number 243 N. Bothel. Ct. 212.31	10g. 0	Citizen of What Co	untry?
36	72 hours after death with the Maryland natural; or items 23a or 28a-1 show lical Examinat must be rudified all	by Funera	11. Marital Status 1	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
2	d within 72 hours piene. r than "naturel; the Medical Ex.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABOYER		Kind of Business/	ruc tion
nd 2	be filed ital Hygi id other event, I	To Be Co	17. Father's Name (First, Middle, Last) LUKE Wilford 18. Mother's Name (First, Middle, Last) MARY	SAV	Age	
-	1 and 2 should Health and Mer em 27 is marke ther treumatic		19a. Informant's Name/Relationship (Type, Print) Wiliam H. Wilford 3531 Highwayla 20a. Method of Disposition 20b. Place of Disposition (Name of Date of Date of Disposition)	5 Hob	or Town, State, Z	10. 73
altimore	Department of hoper Department of himportant: If ite any injury or of		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)		,	11
Bal	permit. Departm importa any inju				BALTO.	W. 22213
	nysician		23a. Part 1. Enter the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rishock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a ASPIRATION FINEUMONIA	espiratory arrest,		Approximate Interval Between Onset and Death 3 DAYS
	/Medical Examiner		Due to (or as a consequence of): CHRONIC ATRIAL FIBRILLATION b.			YEARS
·	be executed sicien and burial-transit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): CEREBROVASCULAR ACCIDENT Due to (or as a consequence of):			YEARS
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.O. Box (ne death certificate be executed the attending physicien and hed for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	very Day Year
ecords, P.	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco		the cause of death?
		Completed		24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
f Vital	Physicien: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 TVNo Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home		6 ☐Other (Spec	cify)
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	af or Attendi safter death. † Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Street City or Town, Sta		ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the Ho within 24 To the Fu completel	M	29b. Signature and title of certifies D 25886	29d. [Pate signed (Monti	4 - 2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS. M.D., 7671 OSLER DRIVE, TOWSON.	MARYL	AND 212	014
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.) Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Month **Physician** Gertrude Arbaugh August 4, 8:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Rockville Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8.4 yrs | Months Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Y May 4, 1 Birthplace (State or Foreign Country)
 MD **Funeral** 1□M 2XF 84 Yrs. Director 212-48-9805 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 238 21234 7400 Old Harford Road United States by Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: ò Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Unk al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unk other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Pages 1 and 2 should be Unknown Unknown Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heatth ar Importent: if item 27 is any injury or other treu once. Cynthia Grady/Social Worker 1235 Potomac Valley Road, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Aug 11 4 □ Donation 5 □ Other (Specify) 20Ő4 Baltimore, MD Mt. Carmel Cemetery 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee M00880 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8717 Green Pastures Drive Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multingorch Pnysician Demend ears /Medical Due to (or as a conseq wince of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Jarry in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician Completed by Physician/Medical the as IF FEMALE USB 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy be detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physicien: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitel o within 24 hours aff To the Funerel DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 565 mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Research MENDHI 31. Date filed Worth Day 1 2004 32 Registrar's Signature State Registrar

Louis Burgess 04-5007 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23pt II per me 6836 10-6-04 tas

Physic	ian	1. Decedent's Name (First, Middle, L	ast)	111 000	-	tificat				2. Date of De	Day	U U 4 Year	
/Medi	cal	Louis Henry Burg								Augus	t 2,	2004	7:15 A M
Exami	ner	4a. Fecility Name (If not institution, gi		ber)		,		Location o			4c.	County of De	
Funeral		205 Orchard Aver 5. Social Security Number 6.		. Age (In yrs.	last birthday)	If Under		yn Pa		8. Date of Bir	rth .	9 B	Arundel irtholace (State or Foreign
Director		Unk	11 ⊠ M 2□F		48 Yrs.	Months	Days	Hours	Min.	(Month, Da May 15	, Year) , 195	66 MD	irthplace (State or Foreigi Country)
pu k		Usual Residence of Decedent 10a. State 10b. County		10a Cit	y, Town or Lo	4:							
shov shov	5	MD Anne An	undol										10d. Inside City Limits 1 ☐ Yes 2 No
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a or	Ö	205 Orchard Aven	16			212						ed Sta	,
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s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examinational De notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	No		fYes,spec 1□Yes 2	. 4	Specify:	, Puerto	Rican, etc.)		Black, Wh <i>Specify:</i> Whi	
72 ho	eted	15. Decedent's E (Specify only highest gi	ducation		16a. Deced	ient's Usua kind of woi			of work	ina	16b. Kin	d of Busines	s/Industry
12 should be filed within h and Mental Hygiene. 7 Is marked other than "raumatic evant, the Med	Completed	Elementary/Secondary (0-12)	College (1-4	for 5+)	life. I	DO NOT us	e retired)	l mig most	OF WORK	, rg	Auto	mobile	2
iled v Tygie ther t		1.2 17. Father's Name (First, Middle, Las	t)		Mecha	nic		18 Motho	r's Name	e (First, Middle	Adaire a f	Promo mo l	
d be intal l	Be c	Unk Unk	,							u Affel		sumame)	
Shoul nd Me mark	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	a Address				al Route Numb		Town State	Zin Code)
and 2:		Carolyn Simmons/								ora, II			2.5 0000/
s 1 and 2 of Health Itam 27 other tra		20a. Method of Disposition			tace of Dispo emetery, cren	sition (Nan	ne of	1	ľ	Date			r Town, State
Pages nent of int: if its iry or o		1 ☐ Burial 2 💢 Cremation 3 (ale	esapea.					ug 10 004	Belt	sville	, MD
permit. Pages 1 and Department of Heali Important: If Itam 2 any injury or other QDC8.		21. Signature of Funeral Service Lice	nsee	2900/m	6 22	Name and	d Addres	s of Facility and		ral Alt	terna Ba	tives ltimor	e MD
Physician / Medical parameter provided in the prijetrians of the prije	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o	r as a consequence as a	uence of):	Embl	plism	M					Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions	4 □ Pregnal 9 □ Unknow	th 2 Fetaint at time of do	death 3 = sath 5 =		ecify)			23e. Did t	obacco us		plivery Day Year to the cause of death?
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7 2 2 2	Certification:	3 Suicide 6 Could not l	28e. Place o	f Injury - At ho g, etc. <i>(Specif</i> y	me, farm, stre	eet, factory	, office			28f. Location (5 City or Tov	Street and wn. State)	Number or F	Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	(Check only 32 X Medical Exa	nysicien: To the b miner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Z.	29b. Signature and title of certifier	Hall, n	40			. License	.C.M.	Ε.			signed (Mon st 2, 2	th. Day, Year) 2004
		30. Name and address of person who Pamela E. South		of death (Item	23a) (Type, I		D	C.L.		D-164			and 21201

		•	For State Registrar		State	of Maryl		artment of F		and Me		iene	1001	25187
	Physici		1. Decedent's Name		Last) Catheri	ne M.	Burges	SS			2. Date of Dea Month August	Day	0.2004	3. Time of Death 6:00am _M
	/Medic Examin		4a. Facility Name (/					4b. City, Town, o	r Location o			_	County of Death	
			Picker	sgill	Retirer	nent 1	Home	Tows				В	altimor	e
	Funeral Director		5. Social Security N 212-05-	8230	6. Sex 1 ☐ M 2 ☐ X F	7. Age (In)	yrs. last birthday Yrs.	Months Days	If Under: Hours	24 Hrs. Min.	B. Date of Birth (Month, Day March 2	Year)	9. Birthp 1906Mar	place (State or Foreign ortry) 'yland
	and w		Usual Residence of 10a. State	10b. County		10c	. City, Town or L	ocation					1	10d. Inside City Limits
	Maryi f sho	ţō	MD	Balti	.more			Ros	edal	е				1 ☐ Yes 2 ☐ No
	r 28a	irec	10e. Street and Nur	nber				10f. Zip Code			1	0g. Cit	izen of What Cour	ntry?
	th wit	ai D	1315 C	hesaco	Ave.			212	37			US	A	
980	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or liems 23a or 28a-1 show od other than "natural", or liems 21a or 28a-1 show event, the Medical Examinar rotate profiled at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed		Armed F	2 € No live	in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√2 No	lispanic Orig an, Mexican Specify:	gin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		14. Race - Americ Black, White, SpecifWhit	etc.
2-0	72 ho	ted	(Sner	15. Decedent	's Education t grade completed)		dent's Usual Occup		t of working	9	16b. K	ind of Business/In	dustry
21	within sene.	Completed by	Elementary/Seco		1	(1-4or 5+)	`life.	DO NOT use retired	d)	I OI WOINING	1	larr	all Dub	h
72	e filed within al Hygiene. other than vent, Tie wa		6th	/Einst Middle /	acti		Insp	ector	19 Mothe	r's Name	(First, Middle, I		ell-Rub	ber
lanc	ould be fi Mental H arked ot atic ever	To Be		am Mea							Carter		Sumame)	
Maryland 21215-0036	2 sho and and is m		19a. Informant's Na			laught		ing Address (Street 5 Chesa						
e, 1	1 and Health Iem 27		20a. Method of Disp		Tield/C	20	h Place of Disn	osition (Name of	1	Da	to	200 10	nostion - Cibror To	num Ctata
mo	Pages nent of int: If it		1 ☑ Burial 2 `4 ☐ Donation		3 □Removal fron ecify)	State	NewCath	matory or other place nedralCe	mete	ry8/	12/04	Bal	ltimore	MD
Baltimore,	permit. Pages 1 am Depirtment of Heal Important: If item 2 any injury or other once.		21. Signature of Fu		1 Con	nell	2	2. Name and Addre		CO	nnelly Balti	Fur	neralHo	meofEssex 1221
ï			23a. Part1. Enter to shock, or hea	he disease, or rt failure. List o	complications that	caused the teach line.	death. Do not en	ter the mode of dyin	ng, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
뷀	Pnysician	8 10	Immediate Cause disease or condition	(Final	. a	ACU	te n	Avter	dial	·	itar	ct	ich	Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a con	sequence of):	Ada		COA	70			
		-	Saquentially list co	nditions,	b. Due to	(or as a cor	sequence of):	MATEL	7 00	3~//		-		Jean
	uted d ansit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rlying injury	_			`						,
oʻ	cate be executed ohysician and the burial-transit		resulting in death) i	Last	Due to	(or as a con	isequence of):							
8760	ate be hysici the bu	dical			d									
9	n certific anding p use as	/Mec	IF FEMALE:		23c. If yes, o	utcome of or	anancy						004 Data -44 Da	
Вох	atte for	Physician/Me	in the past 12	months?	1 Live	birth 2 1	Fetal death 3	□Ectopic pregnancy	′				23d. Date of delive Month	Day Year
o.	the y th sche	hysi	1 ☐ Yes 2 9 ☐ Unknown		9□ Unk	nown								
S, D	requires that een signed b hould be deta	by P	Part II. Other signif	icant conditio	ns contributing to	death but not	resulting in the I	ınderlying cause gıv	en in Part I.		23e. Did tol	oacco u	use contribute to th	ne cause of death?
ord	w require been si should b	ted									1 🗆 Ye	es 21	Nio 3□ Prob	ably 4 Unknown
Records,	law as b 2 sl	ompieted									24a. Was a autops	y	24b. Were auto	psy findings available mpletion of cause of
alF	Th ate pag	O										No.	death?	2 No
Vital		o Be	25. Was case refer examiner?		Hospital:	11	• E = 0 · · ·	Oth	00		Check only on			
of	ig Phys ter this neral di	\vdash	1 ☐ Yes 2 X		28a. Date	of Injury	2 ER/Outpatie	of 28c, Injur	y at		e 5 Heside		6 □Other (Specif) y occurred	Y)
ion	Attanding r death. ector: After by the fune	atio	1 Natural 2 Accident	5 Pending investig		nth, Day Yea	ir) Injury	Wor M 1□	k? Yes 2∐1	No				
Division	2 9 in C	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could n determi	ned 286. Plac	e of Injury - A	At home, farm, st	reet, factory, office		28	If. Location (St City or Town		d Number or Rura	I Route Number,
	Hospital of the hours af Funarel D tely filled in		29a. Certifier	1 Cartifular	Physician: To **	a heat of	knowleden des	th occurred at the tin	ne date a	d place, a	vi due to the -	31160/5	and manner as a	atad
	To the Hos within 24 ho To the Fun completely	edical	(Check only one)	2 Medical E	examiner: On the	basis of exar nner stated.	nination and/or in	ivestigation, in my o	pinion, deal	th occurred	at the time, d	ate and	and manner as so I place, and due to	the cause(s)
	To the Hospital within 24 hours are To the Funarel Completely filled in	₩	29b. Signature and	title of certifier	, /	1.1		29c. Licens	e number		2	9d. Dat	te signed (Month,	Day, Year)
)	6		VOM.	Hote	hony /c	ele	y, m	0 02	299	5		Au	ig usl	10,2004
	8		30. Name and addr	ess of person v	who completed car	Bind	(Type	Print) N. Cl	inte	s St.	Bal	B.	Md Z	10,2004
	Sta Registr	-	31. Date filed (MO	JGT 12	2004 32	Registrar's S	ignature	Spark	/		-			

Registrar

State

31. Date filed (MAUG1 1 2004

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin) ver Nick Road Baltimere Mayluy 2124

		ļ	For State Registrar	State of M		d / Depa		f Healt	th and M		_) [25189
			Decedent's Name (First, Middle, Las	(t)						2. Date of Dea		* 1	3. Time of Death
	Physici	an i		,						Month	Day	Yeer	
	/Medio		ELIZA BELLSER 4a. Fecility Name (If not institution, give	otmot and number			4b. City, Towr	or Locat	tion of Doath	JULY :		y of Death	12:50A ^M
	Examir	ier											
			GENESIS ELDERCAR		in /le uro le	at hinthday	RANDAI		WN nder 24 Hrs.	9 Date of Birth	BALTI		la (C4-4
	Funeral		5. Social Security Number 6. S	ox □M 2□F XX		ast birthday) Yrs.	Months Day			8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
-	Director		250.28.3852 Usual Residence of Decedent	XX	98					DEC 20	, 1905	SUN	ITER, SC
	and w		10a. State 10b. County		10c. City	, Town or Lo	cation					1	Od. Inside City Limits
	laryl eho	5											1 ☐ Yes 2 ☐ No
	28a-1	Director	SC SUMTER		SUM'	TER	101 7:- 0-1				On Citimen of	Mh at Caus	XX
	ath with the Marylar s 23a or 28a-f ehow	ä	10e. Street and Number				10f. Zip Cod	8			0g. Citizen of	what Cour	itry ?
	ath a 234	rai	248 E. REDBAY ST				29151				UNITED		
	Items Items	Funerai	11. Marital Status	12. Was Decedent Amed Forces?	•	5. 13.	Mas Decedent of f Yes, specify C	of Hispanic Suban, Me:	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ick, White,	
36	Saft	by F	1 Never Married 2 Married	1 ☐ Yes ❤️▼ If Yes, Give	No		1 ☐ Yes 2 ☐ I	No Spe	ecity:		Speci	fy:	
00	72 hours after death with the Maryland "netural", or Items 23a or 28a-f ehow olded Exertiliter and be netified at	d D	Widowed 4 Divorced	Year or Dates:		10. 5	XX				101 101 1 15	BLAC	
7	22	Completed	15. Decedent's Ec (Specify only highest gra			(Give	dent's Usual Oc kind of work do DO NOT use ret	ne during	most of work	ing	16b. Kind of E	susiness/in	austry
12	within ene.	E D	Elementary/Secondary (0-12)	College (1-4or	5+)			11100)					
2			17. Father's Name (First, Middle, Last)			HOME	MAKER	10 k	Aothor's Name	e (First, Middle,	OWN HO		
Ĕ	be d la la	Be						10.14		e (1 1131, WILCOTO,	Walderr Surra	110)	
<u>\Z</u>	should the market umatic of	ဥ	WARREN PUGH						REYA				
Maryland 21215-0036	0 0 0		19a. Informant's Name/Relationship (7				-			al Route Number	-		Code)
	s 1 and 2 f Health itam 27 i		LEONARD BELLSER	SON	ach Di		sition (Name of		unk (TIMORE,			
Baltimore,			20a. Method of Disposition 1√√8urial 2 ☐ Cremation √√√	Removal from State	200. Fit	metery, crei	natory or other p	olace)	dire	Jale	20c. Location	- City or 10	own, State
Ē	permit. Pages Department of Important: If i any injury or o		'4 □Donation 5 □ Other (Specify	<i>'</i>)	BRA	ADFORD	CEMETE	RY	ţ		SUMTER	, SC	
<u>a</u>	ppart		21. Siu a di Funeral Service Lice	. PO D	ノ	22 F	Name and Ad	dress of F	HOME	P.A.			
	9 Q F # 9		KELLY CREGORY		MO1148	8 4	26 CRAI	N HW	Y SW G	LEN BURN	IIE. MD	2106	1
п			23a. Part. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each li	d the death.	. Do not ent	er the mode of o	tying, suc	h as cardiac	or respiratory arr	est,		Approximate Interval Between
	Pnysician	23a. Part. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition											Onset and Death
/Medical disease or condition resulting in death) a													
	Examiner		O No the first and this are	b									
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of highly that initiated events	Due to (or as	a consequ	ence of):							
	cuted Id ransi	Examine	Cause (Cisease of injury that initiated events	C									
ó	be executed siclan and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
160	a × a	cai		d									
68	The law requires that the death certificat tte has been signed by the attending phy age 2 should be detached for use as th	led	15.555										
Вох	h cei	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Ectopic pregna	ncv			1	ate of delive	,
	deat	Cic	in the past 12 months? 1 □ Yes ♣️No	4☐Pregnant a 9☐Unknown			Other (specify,				M	onth	Day Year
0	that the de ted by the a detached t	Physician/M	9 □ Unknown	9LI UNKNOWN						14			
ď,	es the igned be de	by F	Part II. Other significant conditions of		out not resu	Iting in the u	nderlying cause	given in P	Part I.	23e. Did to		tribute to th	ne cause of death?
Vital Records,	quire an sig	ed t	DEMETIA, ANEM	IA						1 □ Y	es ŽNo	3 🔲 Prob	ably 4 Unknown
00	law requas been 2 should	jet	STROKE, HYPER	TENCTON						24a. Was a		Were auto	psy findings available
R	The la	Completed	DINUNE, HILEN	TENDION						autops perfor	ned?	death?	mpletion of cause of
a		Ö	25. Was case referred to medical					26.5	Place of Deatl	h (Check only or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 140
5	Physician: this certific ral director,	0 8	examiner? 1 □ Yes 2√√No	Hospital:	ant 2□E	B/Outpatier	t 3 DOA			me 5 Resid		per /Specifi	v)
of		H	27. Myrnger of Death	28a. Date of Inju	iry	28b. Time of		njury at Work?		28d. Describe h			//
O	th. : After s funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury		Vork? □Yes :	2 □No				
Division	Attending r death. ector: After by the fune	fice	3 ☐ Suicide 6 ☐ Could not be	288. Place of Inj	jury - At hor	ne, farm, str	eet, factory, office	СӨ		28f. Location (S	treet and Num	ber or Rura	l Route Number,
á	after Dire	Certification;	4 Homicide	building, et	tc. (Specify,)				City or Tow	n, State)		
	Hospital		29a. Certifier Certifying Ph	ysician: To the best	of my know	vledge, deatl	n occurred at the	e time, dat	te and place,	and due to the c	ause(s) and m	anner as s	tated.
	the Hospital or Attendi within 24 hours after death. It the Funaral Director: A campletely filled in by the fu	Medical	(Check only 2 ☐ Medical Exemone)	niner: On the basis of and manner st	it examinati	on and/or in	vestigation, in m	ny opinion,	, death occurr	red at the time, d	ate and place,	and due to	the cause(s)
	To the Within 2 To the complet	ž	29b. Signature and title of certifier	1		1	29c. Lice	ense numl	ber	2	9d. Date signe	ed (Month,	Day, Year)
)				11~	7/	12	10 50	2260		The state of the s	TITE V. Č	0 20	0.4
	K		30. Name and address of person who	completed cause of c	death (Item	23a) (Type,		2360			JULY 3	u,ZU	V4
			KULBIR SANDHU, M				·	ישידוו	300 D	IKESVILI	F MD	21200	
	Sta	ite	31. Date filed (Month, Day, Year)		rar's Signat	ure-	1		JUU I	-rug v Lli l	till -	-1400	
	Regist	ar	AUG 1 1 2004	Serve	a /		pour						

			1 - State of Mar		artment of Health and M rtificate of Death	Mental Hygier	10 () in 1	25100
	Dhusis		Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
	Physici /Medi	al		ewtry		8 6	2004	11:21 AM
7	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	12
	Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthp	place (State or Foreign
	Director		280 30 5394 1/2M 2DF	L9 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, Yea	1935	Ohio
	anyland ahow		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	ocation		1	0d. Inside City Limits
	the Maryla 28a-f ahor	ctor	Maryland Baltimore	Chas	88			1 ☐ Yes 2 ☐ No
	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Mudical Exprehen must be notilled at	Director	10e. Street and Number LESIZ Rd.		10f. Zip Code 21220	1	Citizen of What Cour	1
	death тв 23	Funeral	11. Marital Status 12. Was Decedent Ev	er in U.S. 13.			14. Race - Americ	tates
9	after dea or Items	Fur	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 → No Specify:	Rican, etc.)	Black, White,	etc.
8	72 hours "natural", idical Exe	ed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		dent's Usual Occupation	105	7.	12
215	hin 72 s. in "na Medic	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during most of work DO NOT use retired)	king 160.	Kind of Business/Ind	dustry
21	be filed within tal Hyglene. d other than event, the Man	Сош	12	Serv			Service	
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last) George Bratty		18. Mother's Nam	e (First, Middle, Maid	hunk	
ary	d 2 should Ith and Men I7 le marke traumatic	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rur			Code)
	Health a Health a tem 27 le		Juanita Beatty / Spouse	7800	1-0-1	Chase, MD	21220)
altimore,	permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other to		20a. Method of Disposition 1	20b. Place of Dispo cemetery, crer	matory or other place)		Location - City or To	1 1
Itim	artmer ortant Injury		* 4 □ Docation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	OAK LAW	Name and Address of Facility		DA ITIMOTE,	Maryland
Ba	permit. Departm Importa any Inju			Co	nnelly Funeral Ho	Dyndal	MANK, P.	4. 21222
	Physician /Medical Examiner	25 0	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each one. Immediate Cause (Final disease or condition resulting in death) Due to (or as a condition should be conditions)	ncos le	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	tate be executed by sician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Dibase) or if in y that initiated events resulting in death) Last Due to (or as a continuation of the co					
O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	ompleted by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at times) 1 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ny Day Year
rds, P	w requires tha been signed I should be det	ed by P	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in Part I.	11	o use contribute to th	e cause of death? ably 4 Unknown
Vital Records,		Complet				24a. Was an autopsy performed?	prior to con death?	osy findings available npletion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		04	h (Check only one)	will the same	1817 131 13
of	Phys this ral dia	. To	1 ☐ Yes 2 ☐ No	2 ER/Outpatien	t 3 DOA Other: 4 Nursing Ho 28c. Injury at Work?	ome 5 Residence 28d. Describe how in		')
ion	Attending ir death. ector: After by the fune	atlor	1 Natural 5 Pending (Month, Day Y 2 Accident investigation (Month, Day Y	'ea <i>r)</i> Injury	Work? M 1 ☐ Yes 2 ☐ No		,,	
Division	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc. (- At home, farm, stri	eet, factory, office	28f. Location (Street . City or Town, Sta	and Number or Rurai	Route Number,
D	Hospital o		29a. Certifier 1 Certifying Physician: To the best of r					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of reaching Physician: To the physician: To the best of reaching Physician: To the physician: To the physician: To the phys	camination and/or inv	occurred at the time, date and place, vestigation, in my opinion, death occurr	and due to the cause red at the time, date a	(s) and manner as stand due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	29d. C	Date signed (Month, L	Day, Year)
•	./		My (N')		D1848/		8/9/00	1
	9		30. Name and address of person who completed cause of deal MYO THANT BILM SAND	PIPER C	Print) IRCLE, BALTIN	WRE, MT	21236	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	i)			

				State of Marylan				-	•	
			1 - For State Registrar	·		rtificate of		, ,	eg. No. 1 1 L	25191
			1. Decedent's Name (First, Middle, Last,)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Ruth	N •		Во	yd	August	2 2004	MACHI
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of Dea	ith
				of Bellmore		Beltimor				
	Funeral		5. Social Security Number 6. Set	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		218-18-3479 Usual Residence of Decedent	09				04 24	15	MD
/land	Mo		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
Man	무렴	to	MD NA	g	altim	OKA				1X Yes 2 □ No
h the	288	Director	10e. Street and Number		al Li	10f. Zip Code	•	1	0g. Citizen of What C	ountry?
death with the Maryland	ital Hygiene. id other than "natural", or items 23a or 28a-1 ehow event, the Medical Examinar must be notified at		3000 Towanda Av	e		21	215		U.S.A	•
	SE JE	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of I	Hispanic Origin? (Sp Jan, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whi	
afte	or it		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 ☐ No		. ,	Specify:	,
Z13-UUSD	urai'	d by	3 Widowed 4 Divorced	Year or Dates:	10.5					
27 27	uat Edici	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of work	king	18b. Kind of Business	/Industry
- '₹	than than	щ	Elementary/Secondary (0-12)	College (1-4or 5+)				<u> </u>	ochild C	ohon
D D	Hygic other ent, II		12th grade 17. Father's Name (First, Middle, Last)	na	D	uyer	18. Mother's Nam		Maiden Sumame)	onen
yland ould be file		To Be	Arthur Williams				Nellie	Pavne		
E . S	and Menta is marked sumaticev	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address (Street	·		, City or Town, State,	Zip Code)
Mal nd 2 st	# 2 E		Evelyn Presiden	t-Daughter	5200	Bowley	Lane, 1	Baltimo	re, Md	21206
S 1 S	of Hear item		20a. Method of Disposition	20b. F	Place of Dispo	osition (Name of matory or other pla			20c. Location - City or	Town, State
Pao	ant: If		1 Marial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	ionioval nom State				8/9/04	Owings M	ills, Md
baltimore,	Department of I important: If its eny injury or of once.		21. Signature of Funeral Service Licens	ee CVA-) 2: M	2. Name and Address Rarch F/	ess of Facility			
11 8	.ŏ.⊑ 5 8		Manyon	DXI Kes	/ 4	300 Wab	ash Ave	, Balti	more, Md	
			23a Fart1. Enter the disease, ox compleshock, or heart failure. List only or	ications that coused the deat no cause on each line.	th. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory arra	est,	Approximate Interval Between
	rysician		Immediate Cause (Final disease or condition	Sibarachood	العادك	rd + I	transchal	v Henner	hie	Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a conseq	quence of):		d bran		3	
		<u></u>	Sequentially list conditions,	Due to (or as a conseq	feret e	of box	d ban	the kon		50,55
ted	nsit	F	Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury	200 10 (01 40 2001.000)	,40.100 01).					
ou, be executed	sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	juence of):			-		
00/ epge	/sicie e buri	cail		i						
The law requires that the death certificate	igned by the attending physi be detached for use as the l	큣						Y		
DOX	endin use	an/Me	23b. Was decedent program	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		∃Ectopic pregnanc	v		23d. Date of de	
deat	ne att	sicis	in the past 12 months? 1 □ Yes 2 ☒ No	4 Pregnant at time of d		Other (specify)	, 		Month	Day Year
T ta	l by the	Physicia	9 Unknown						Tables.	
S, Tes th	igned be d	ğ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	inderlying cause gi	ven in Part I.		pacco use contribute to	
Ord requi	been si should	ted	Hypurkisian					1 L Y €	es 2.MNo 3□P	robably 4 Unknown
Records he law requires	has b e 2 sl	Completed	Paset disease					24a. Was a autops	y prior to	utopsy findings available completion of cause of
	(0	Co	Hesophergracil forz	of unknown	etalos	7		perform 1 ☐ Yes 2		2 □ No
OI VIIAI Physician: T	h. After this certific funeral director,	Be	25. Was case referred to medical examiner?	Hospital:		l Ct	26. Place of Deat			
Phys	al d	. To	1 ☐ Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatier	II JUDON	4 Nuising no		ence 6 Other (Spe	ecify)
ding	h. After	tion	1 XNatural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Wo	rk? Yes 2 🗆 No	200. 50001150 110	on injury cocurred	
UIVISION I or Attending	dea ctor	ertification:	3 Suicide 6 Could not be	28e. Place of Injury - At he				28f. Location (St	reet and Number or Ri	ural Route Number,
	after i Dire	Cert	4 Homicide	building, etc. (Specif	(y)			City or Town	n, State)	
Spite	hours inera y fille	aic	29a. Certifier Certifying Phy	sician: To the best of my kno	owledge, deat	h occurred at the ti	me, date and place,	and due to the ca	ause(s) and manner as	s stated.
he He	within 24 hours after death. To the Funeral Director; After completely filled in by the funeral completely filled in the funeral complete	edicai	one)	ner: On the basis of examina and manner stated.	ation and/or in	ivestigation, in my	opinion, death occur	red at the time, di	ate and place, and due	e to the cause(s)
Tot	To 1	Σ	29b. Signature and title of certifier			29c. Licen		2	9d. Date signed (Mont	th, Day, Year)
((1.)		41 West	5 DO		RES	-000		August Z	2004
	110	1	30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,				•	
	- 01		Jenniter C. Wheek 31. Date filed (Month, Day, Year)	32. Registrar's Signa	FD H a	Bellmore				
	Sta Registr		AUG 1 1 2004	San San San San San San San San San San	/	,				

DHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	State of Ma	_		of Health and I of Death	, ,	ene . N2. A A L	25102
Physicia	an	1. Decedent's Name (First, Middle, Last RDB-CRT S. BE	ZONN, J	R			2. Date of Death Month	Day Year	3. Time of Death 3:23AN
/Medic Examin		4a. Facility Name (If not institution, give	street and number)			own, or Location of Death		4c. County of Dea	ath
Funeral		GILCHRIST CEI 5. Social Security Number 6. Se	XTER 7. Ag	e (In yrs. last birtho	day) If Under 1				MORE thplace (State or Foreign
Director		213-62-7342 10 Usual Residence of Decedent	2 M 2□F	50 Yr	s. Months I	Days Hours Min.	Month Day, Y	ear) C	thplace (State or Foreig ountry) VA
ehow		10a. State 10b. County	12100	10c. City, Town o					10d. Inside City Limits
with the Marytar s or 28s-f ehow be notified at	Director	MD BALTII 10e. Street and Number	MORE	BAL	TIMOR 101. Zip C		10-	. Citizen of What C	1 Yes 2 XN
th with 23a or ust be	ai Di	1221 HARNALL	ROAD		101. 240	21207	Tog	U.S	
17215-0036 within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow then "matural" or Items 21e or 21fied at its Modical Examilinar must be notified at	Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13. Was Deceder If Yes, specify	nt of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	erican Indi <i>a</i> n, te, etc.
Mad y fail to Z Z 3-0030 d 2 should be filed within 72 hours aft th and Madual Hygienal 77 is marked other than "natural, or traumatic event, it a Madical Exami	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 页			Specify: B	LACK
nin 72 t n. "nati M. dies	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	- (G	ecedent's Usual (Give kind of work fe. DO NOT use	Occupation done during most of wor. retired)	king	b. Kind of Business	,
filed withi Hygiene. other than	Com	17. Father's Name (First, Middle, Last)	2 years	(+)	FIREFI				RE CITY
2 should be filed within 72 ha and Mental Hygiene. is marked other than "natur raumatic event, It's Mudical	To Be	ROBERT BROV	UN, SR.				ne (First, Middle, Ma A I M A		
ges 1 and 2 should be t of Health and Mental if item 27 is marked or or other traumatic even	-	19a. Informant's Name/Relationship (7)				Street and Number or Ru	ral Route Number, C	ity or Town, State,	
Health tem 27 i		LORETTA W. BRO 20a. Method of Disposition	MIO		isposition (Name crematory or othe		BALTIMI Date 20	c. Location - City or	
permit. Pages 1 ar Department of Hea mportant: ff item: any injury or other		1 XBurial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		crematory or other		10.04		
permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licens			VAUGHT	Addrass of Facility V.C. GALLENE HLTO, NATION	FUNERAL AL DIVER	Service	21220
		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused ne cause on each lir	the death. Do not					Approximate Interval Between
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):		nyelom	n		Onset and Death Services
Examiner		Sequentially list conditions,	0.			3570			U
uted d ansit	Examiner	if any, leading to immediate cause. Ent or Underlying Cause (Disease or Injury that initiated events	Due to (or as	a consequence of):					
		resulting in death) Last	Due to (or as	a consequence of):					
= D 6	edicai		1			-			
eath certifi attending for use as	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pregi			23d. Date of de	livery Day Year
at the de by the a tached f	hysic	1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at 9☐ Unknown	time of death	5 ☐ Other (speci	fy)		Month	Day rear
res that igned b	by P	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in th	e underlying caus	se given in Part I.			the cause of death?
law requii as been s 2 should	Completed						24a. Was an		utopsy findings available
	Con						autopsy performed 1 ☐ Yes 2 🔀	<pre>f? death?</pre>	
- 0 2	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No	fospital:	nt 2□ER/Outpa	tient 3☐ DOA	04	th (Check only one)	6 Other (See	ou Hasnica
l or Attending Physician: The law requires that death. Director: After this certificate has been signer in by the funeral director, page 2 should be d		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		e of 28c.	Injury at Work?	28d. Describe how i		city) ITOSUICE
To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ıry - At home, farm,	M street, factory, o	1 Yes 2 No	28f. Location (Stree	t and Number or Ru	ural Route Number,
itel or urs after ral Dire	Cert	4 Hornidae	building, etc				City or Town, S	tate)	
e Hosp 24 hou e Fune etely fil	edicai	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and/or	eath occurred at to r investigation, in	he time, date and place, my opinion, death occur	and due to the caus- red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	1-0		29c. L	icense number	0	Date signed (Monta	-
	-	30. Name and address of person who co	y Killy	ath (Item 22s) (T	() c	32902	1.7	ugust	5,2004
r		W. A. Riley G		701 N- (. St. Bal	to and	21205	
Stat Registra		31. Date filed (Month, Day, Yéar)	32. Registra	y's Signature	4 1	loca Val			

		Please Type or Print in Bla Unpend item #23a, 27, per ME, State of Maryland /		tificate of			Reg. No. () ()	25193
Physici	an	Decedent's Name (First, Middle, Last) James Francis Burnside				2. Date of Dea	Day Ye	
/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death	August	4c. County of D	
		9814 Homeland Avenue 2nd floor 5. Social Security Number 6. Sex 7. Age (In yrs. last t	into de 1	Par	kville		Baltim	
Funeral Director		5. Social Security Number 6. Sex 214–46–0963 6. Sex 2 1 7. Age (In yrs. last I	Yrs.	Months Days		8. Date of Birtl (Month, Day March 2	1 Year 1948 M	Birthplace (State or Foreign Country) aryland
land		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Loc	ation				10d. Inside City Limits
e Mary 3a-1 sh	ctor	Maryland Baltimore Parkvi	lle					1 ☐ Yes 22 No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Menlal Hygiene. Department of Heath and Menlal Hygiene. Importent: If tiem 27 is marked other then "naturel; or Iteme 23a or 28a-1 show any injury or other treumatic event, I're Medical Examiner must be notified at once.	Director	10e. Street and Number 9814 Homeland Avenue		10f. Zip Code 21234		1	10g. Citizen of What USA	Country?
r death eme 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decedent of Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	merican Indian, /hite, etc.
036 urs afte at, or It	by Fu	1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: ✓ 💦 💦		☐ Yes 2 No		, , , , , , , ,	Specify: W	
5-00 72 hou mature	eted	1	(Give k	ent's Usual Occu	during most of work	ing	16b. Kind of Busine	ss/Industry
2121 3 within piene. r then "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ονοτuse retire al Direc	,		Funeral Se	ervice
Baltimore, Maryland 21215-0036 semit. Pages I and 2 should be filed within 72 hours alt Department of Health and Medlal Hygienth mportent: If item 27 is marked other then "naturel; or any injury or other treumatic event, I a Madical Exami	0	17. Father's Name (First, Middle, Last) James F. Burnside, Jr.			18. Mother's Name Betty St	e (First, Middle,		
aryla should nd Mer marke	70	•	b. Mailing	Address (Street	t and Number or Rura		r, City or Town, State	a. Zip Code)
and 2 ealth a m 27 is		Lynn Schroeder / Wife 1	739	NW 80th	Ave, #J,	Margate	, Florida	33063
nore ages 1 ant of H t: If ite				ition <i>(Name of</i> atory or other pla le Veter			20c. Location · City	or Town, State le, Maryland
Baltir Permit. P Departme Importen any injury		21. Signature of Funeral Syrvice Licensee	-					ral Homes, Pi
a 88 8 8		Haris J. Wiles	53	11 Edmor	ndson Aven	ue Balt:	imore, Mar	ryland 21229
Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure List only one cause on each line. Immediate Cause (Final disease or condition					rest,	Approximate Interval Between Onset and Death
/Medical		disease or condition resulting in death) a. ATTERIOSCIENC Due to (or as a consequence)		Catulova	ascular u	sease		
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ecuted and -transit	camine	that initiated events c.	0					
ds, P.O. Box 68760, ures that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	cai E	Due to (or as a consequence	B UI).					
K 68 entificat	Medi	IF FEMALE:						
Box death certifications at attending d for use a	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal deal 4 Pregnant at time of death		Ectopic pregnanc Other (specify) _	ey .		23d. Date of o Month	delivery Day Year
b, P.O.	Phys	9 ☐ Unknown	?- Ab	44-7		00- 5:4-4		
rds, luires the n signe	by	Part II. Other significent conditions contributing to death but not resulting	in the und	perlying cause gi	ven in Part I.			to the cause of death? Frobably 4 Unknown
Records, The law requires te has been sign	Completed					24a. Was a autops	an 24b. Were	autopsy findings available o completion of cause of
ral R n: The ficate t or, page		OF Wee goes referred to medical				perform 1 Yes	med death 2 No 1 ☐ Y	? es 2□ No
of Vita Physicien: this certific	To Be	25. Was case referred to medical examiner? 1 [XYes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/C	Outpatient	3□ DOA Ott	26. Place of Death her: 4 \(\sum \) Nursing Hor			pecify) At scene
on of Vital Rec ding Physicien: The lav n. After this certificate has funeral director, page 2.		1 Aatural 5 Pending (Month, Day Year)	Time of Injury	28c. Inju Wo	ryat irk?]Yes 2 □ No	28d. Describe ho	ow injury occurred	
Division of Vital Records, I or Attending Physicien: The law requires that deter death. Director: Alter this certificate has been signed in by the funeral director, page 2 should be control or the funeral director, page 2 should be control.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	farm, stre			28f. Location (St City or Town	treet and Number or	Rural Route Number,
Ditel or phel or after after and Direction illed in								
Division C To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: Alfert completely filled in by the funera	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☐ Medical Examiner: On the basis of examination a and panner stated.	ge, death ind/or inve	occurred at the ti estigation, in my o	me, date and place, a opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
To ti Within To ti	M	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed (Mo	
		U Many	\ (Tupo P		C.M.E.		August 05	D, 2004
12+1		30. Name and address of person who completed cause of death (Item 23a						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Yeer 0 02 5:00 AM UMILTA BARNES 2004 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Millennium Nursing Home Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M XXF Yrs. Trinidad 121-46-4118 54 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Street 21216 U.S.A. 2112 Rosedale 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Walter Reed Hospital Book Keeping 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Pierre Enid Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2112 Rosedale Street, Baltimore, Md 21216 Kareem Barnes-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 5 Other (Specify) ⁴ 4 □ Donation 8/10/04 Baltimore, Md Metro Crematory March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a ALQUIRSO IMMUND DEFICIENCY SYNDROME disease or condition resulting in death) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

in then "natural", or Itams 23a or 28e-1 show

Completed by Funeral Director

Be ဥ

with the Maryland

filed within 72 hours after death

al Hygiene.

permit. Pages 1 and 2 should be filed v. Department of Health and Mental Hygies Importent: If Item 27 is marked other the any injury or other treumatic event, the once.

Maryland 21215-0036

Baltimore,

Examiner attending physicien and for use as the burial-transit Physician/Medical signed to Medical Certification: To Be Completed by

F

Hospitel or Attending Physician: The law requires that the death certificate be executed

this

To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: At

completely

P.O. Box 68760.

Division of Vital Records,

Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	
that initiated events resulting in death) Last	C. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	
Part II. Dther significant condition	ns contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to

		23d. Date of		Year
art I.	23e. Did tobacc	an usa contribu	ato to the cou	use of death?
an I.	1	_		4 Unknown

			24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical		26. Place of Death (C	Check only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury	Injury at Work? 1 Yes 2 No	d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined	uld not be as Blace of Injury. At home form street feature effice.		f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Pt	nysicien: To the best of my knowledge, death occurred at the	he time, date and place, and	due to the cause(s) and manner as stated

	on and/or investigation, in my opinion, death occurred at the tir	
b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 1 1 10 -	DIN59107	128 120 2

			0 10		100	-
30. Na	me and addre	ss of person who	completed cause of dea	th (Item 23a) (Type,	Print)	12
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-	2600	MBER	TY	HE	160	275	AV	
awa	BALTIN	WRE	\wedge	- D	2	-12	15	

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death Decedent's Name (First Middle Last **Physician** August 8, 2004 5:00 P Frank Arthur Borsella /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 4818 Greencrest Road 8. Date of Birth (Month, Day, Year) September 26, 1929 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1**X** M 2□ F Months Days Hours 74 Maryland Director 216-24-3290 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State 28a-f show other traumatic event, the Medical Exarchine must be notified at 1 Yes 2 □ No Baltimore Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ŏ USA 21206 4818 Greencrest Road or items 23a by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural, or Ite 1 Never Married 2 Married YYes 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Maryland Fuel Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Smith John Borsella ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health an.
Important: If flem 27 la m.
any injury or other. 19a. Informant's Name/Relationship (Type, Print) 4818 Greencrest Road Baltimore Maryland 21206 David Borsella/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 8/11/04 Hilltop Service Corp. Towson Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility 5305 Harford Road Baltimore Maryland Leonard J. Ruck, Inc. hustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Renal Failure Pnysician 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner < 4-5 months Hydronephrosis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consquence of): Examiner the burial-transit certificate be executed Cancer years Colon Metastatic Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Š signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Anemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an -oronany Arten autopsy Hematuria 2 X No 1 Yes 2X No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl
 A hours after death.
 Funeral Director: After the Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the Vithin 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 0055698 August 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21201 Jang MD Sungyon C. 10 N. Greene St. Baltimore, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ooth AUG 1 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JATNO **Physician** Month RIBAR 2004 August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner HARBOR 1920H OF N/A 8. Date of Birth (Month, Day, May 20, If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Min Hours 1 ☐ M 2X F 54 214 54 8961 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location r 28a-f ehow 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "naturel", or Items 23a or tre Medical Examiner med be 113 - 12th Avenue 21225 U.S. filed within 72 hours after death v Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked other any njury or other traumatic event, 9066. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Francis Bathon Audrey Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 - 12th Avenue John Confair Jr. / Husband Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 8/7/2004 *4 □ Donation 5 □ Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee rant. Enter the dise secured plications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 23a art1. Enter the dise Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VOLTU /Medical Due to (or as a consequence of) **Examiner** > Si Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 🔭 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has this certificate 2 1 🗆 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes No ۵ 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Acquist GOORES

State Registrar

31. Date file

DHMH 17 Rev 1/2001

ser Street

30015.

62. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPI'tal

			State	partment of Health and Nertificate of Death		
	Ø*		Registrar 1. Decedent's Name (First, Middle, Last)	ortinoate or Boatin	2. Date of Deat	
	Physici /Medic		Wayne Timothy Clar	k	Angni	5) 5th ZVOY 8:30PM
	Examir		4a. Facility Name (If not institution, give street and number) North Arndi Hospital	4b. City, Town, or Location of Death	7-2	4c. County of Death Armdal
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 220 58 2068 1 ™ 2□ F 48 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Dec. 19	Year) 9. Birthplace (State or Foreign Country) Maryland
	and		Usual Residence of Decedent 10c. City, Town or 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Maryl -f sho	tor	Maryland N/A Baltin	nore		1 X Yes 2 □ No
	th the	Director	10e. Street and Number	10f. Zip Code	10	0g. Citizen of What Country?
	s 23a		4207 Doris Avenue	21225	it. V or No	U.S. 14. Race - American Indian,
Ç	Baltimore, Maryland 21213-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evaminar riust be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 1 □ Yes 2 ☒ No 1 □ Yes Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☒ No Specify: 	o Rican, etc.)	Black, White, etc. Specify: White
č	72 hou	ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work	kina	16b. Kind of Business/Industry
3	vithin 7	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) ongshoreman	ig	Shipping
7	filed v Hygie Sther t		10th L 17. Father's Name (First, Middle, Last)		ne (First, Middle, M	
	/lan uld be Mental irked tic ev	To Be	Donald Clark	Arc	dith Beam	non
	Aary 2 sho and ! Is ma	·		ailing Address (Street and Number or Ru		
	e, R 1 and Health em 27 ther t		20a Method of Disposition 20b. Place of Di	sposition (Name of		Maryland 21225 20c. Location - City or Town, State
	MOF Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) Entombment Glen Hi	crematory or other place) aven Mem. Park 8/9	9/2004	Glen Burnie, Maryland
:	Baiti permit. Departm Importa any inju		21. Signature of Funeral Service License			eral Service, P.A. timore, Maryland 21225
		Г	23a. Part1. Enterthe disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		_=	est, Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	testinal b	7/2 40	Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	c Carabocis		
IJ		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that individual early the control early to the control early the c	1	C- 1.	
	8 / 60, sate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	his Cin	tection	Y 7
J	8 760, sate be exphysicien the buria	dicail	d			
,	OX 68 certifica nding ph use as th	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			2010 2011
	death death e atte	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
01	S, P	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		pacco use contribute to the cause of death?
N	() ≥ Q (i)	Completed			24a. Was ar	
~ 1	Vital Re sician: The lav certificate has rector, page 2	Com			perform	
7	Of Vital Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	Other	ath (Check only one	
	Of Phys this ral di	7: To	27. Manner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at	lome 5 Reside 28d. Describe ho	nce 6 Other (Specify) w injury occurred
2.	anding ath. or: Afte	atio	2 Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		
	DIVISION al or Attending s after death. al Director: Afte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
	Division of Vital Reference of the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dependent on the basis of examination and/or and manner stated.			
	To t withi To tt	Σ	29b. Signature and tille of certifier, MD	V 4800 b	25 A	ngust 5th 2004
	1 0		30. Name and address of error who completed cause of death (Item 23a) (Ty	Hospital Dr.	Glan	Bunit, mD 21061
	Sta Regist	ate rar	AUG 1 1 2004	Sports		

NA

10b. County

10a State

Md.

William

21. Signature of Funeral Service Licensee

Director

þ

Completed

Be

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Medical Examiner must be notified at

permit. Pages 1 and 2 should be illed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, If e Media 90R8.

Physician

/Medical

Examiner

burial-transi

the attending physicien

been signed by

this certificate has

After t

To the Hospital or Attending I within 24 hours effer death.
To the Funeral Director: After

detachad

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Examiner

Completed

Be

P

Certification:

Medicai

Lager, Johnnie

natural, or items 23a

Cager 4b. City, Town, or Location of Death Baltimore

Day Month Year 2004

2. Date of Death

3. Time of Death 2:30A M

10d. Inside City Limits

1 ¥Yes 2 □ No

1120

4c. County of Death

NA Birthplace (State or Foreign Country)

Smith

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

21202

Approximate Interval Between Onset and Death

Year

2009

Baltimore, Md.

2 **X**No

8. Date of Birth (Month, Day, Year) 1 - 2 - 14N.C

Baltimore

Esther

10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?

2434 W. Belvedere Ave. 21215 USA 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify.

Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry

Elementary/Secondary (0-12) College (1-4or 5+) ŪNKN Homemaker Other People Homes

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)

10c. City, Town or Location

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1311 E. Federal St., Baltimore, Md. Sandra E. Whitehurst Cousin

20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 8-9-04 Woodlawn Cem. Baltimore, Md.

22. Name and Address of Facility

Warch F.H. East I and 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

End Demen Ti

Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

Cager

Directo (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy

in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 9 Unknown 9 Unknown

5 Other (specify)

Month Day

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 KNo 3 Probably 4 Unknown

24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier 1126 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature apd title of certifier

D56508 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W Belvedere

31. Date filed (Month, Day, Year) State AUG 1 1 2004 Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

n

souls

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause of deem (Item 23a) (Type, Print)

2. Registrar's Signature

TODOREMIK

31. Date filed (Month, Day, Year)

AUG 1 1 2004

			1 - For State Registrar	State of Maryla	•	artment of H		,	giene Reg. N69	. 25200
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last William J. 4a. Facility Name (If not institution, give	Carton, Jr	•	4b. City, Town, or	Location of D	2. Date of Dea Month August	Day Ye	1:30AM M
	Funeral Director		Manor Care 5. Social Security Number 497–16–5432 6. Se	x 7. Age (In yrs	s. last birthday, Yrs.	Towson If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Da. July 15	Baltim b, Year) 9. 1919 M	Ore Birthplace (State or Foreign Country) issouri
	death with the Maryland ims 23a or 28a-f show	Director	Usual Residence of Decedent		City, Town or L	ocation 10f. Zip Code			10g. Citizen of Wha	10d. Inside City Limits 1 □ Yes 2 🛣 No t Country?
		by Funeral	204 East Joppa Roa 11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?	U.S. 13. WII Era	21286 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	ispanic Origin' In, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	United S 14. Race - A Black, V Specify:	tates American Indian, Vhite, etc. White
-61212 DI	e filed within 72 hours after ul Hygiene. other than "netural", or Ite vent, It e Neulical Exarchia	se Completed	15. Decedent's Edi. (Specify only highest grad Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	cation (e completed) College (1-4or 5+) 5+	(Give	Indent's Usual Occup Is kind of work done of DO NOT use retired Cutive	during most of ()	Name (First, Middle,	Electri Maiden Sumame)	
₹ .	id 2 should be th and Menta 27 Is marked traumatic ev	ToB	William J. Carton 19a. Informant's Name/Relationship (7) Frances C. Pauley	vpe, Print)				Rural Route Numbe		re, Zip Code) Ssouri 63005
	it. Pages 1 an rtment of Heal rtant: If itam 5 njury or other		20a. Method of Disposition 1	Ca	Place of Disponentery, creeding (osition (Name of matory or other place Cemetery	8/6	Date	20c. Location - City St. Louis	
	Physician Medical Caraman Caraman	23a. Part Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	M0111 iications that caused the deine cause on each line. a. Due to (or as a conse	3 72 ath. Do not en	233 De1mai	Boule	vard, St.	Louis, M	Approximate Interval Between Onset and Death	
,00/00	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)	/	MIPLE	56 A sadi	rt		
.O. DOX	the death certi y the attending iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[⊒Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
scords, r	aw requires that the death certific as been signed by the attending p 2 should be detached for use as	Completed by Pf	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	underlying cause give	en in Part I.	23e. Did to 1	res 2 No 3 □	e to the cause of death? Probably 4
אוושוו א	sician: The l certificate harector, page	Be	25. Was case referred to medical examiner?	Hospital:		other control of		perfor 1 ☐ Yes Death (Check only or	med? death 22 No 1 0	n? Yes 2□ No
JIVISION OI	tanding Phys leath. tor: After this the funeral di	Certification; To	27. Manner of Death Vatural 2 Accident 3 Suicide 5 Pending investigation 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Work	Nursin		ow injury occurred	
2	To the Hospitel or Attanding Physician: The law within 24 burus after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2 v.		4 Homicide determined 29a. Certifier 19 Certifying Phy	28e. Place of Injury - At building, etc. (Special Sician: To the best of my known and the second sec	nowledge deal	th occurred at the tim	ne, date and pl	City or Tow	n, State)	Rural Route Number,
	To the H within 24 To the Fi complete	Medical	29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	iation and/or in	29c. License			29d. Date signed (M	
5	Sta	te	30. Name and address of person who could be a second address of person who could be a second and address of person who could be a second address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person who could be a second and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person address of person and address of person a	ompleted cause of death (Ite P A 32. Registrar's Sign	up s	Print) 905 Q	nacia	that He	105 40	21082
	Registr	ar	AUG 1 1 2004	Denes a	O A	Docke!				

Robert Dring 04-05096 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2004 ear **Physician** August 06, ROBERT DRING 0024 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Shock Trauma Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 6/3/1964 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1**XX**4 2□ F Days Hours Min 40 MARYLAND 213-82-6640 Yrs. Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10a. State 10b. Counts 10d. Inside City Limits Show MD or Items 23a or 28a-f sh Fultier parat be putilized ANNE ARUNDEL GLEN BURNIE 1 ☐ Yes 2 XX Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 DELMAR ROAD 21061 USA Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XX If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo WHITE Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 ENVIRONMENTAL TECH ENSR INTERNATIONAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Mental Is marked HAROLD D. DAVIS RUBY MAE AUSTIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai <u>once</u>. PAMLA S. DRING - WIFE 522 DELMAR ROAD, GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State HOLY CROSS CEMETERY 18/10/2004 * 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service L 22. Name and Address of Facility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 FINK #M01148 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List of by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician tiple NY disease or condition resulting in death) mul /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): O. Box 68760 Physician/Medical guipt IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 Z Yes 2 ☐ No certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 70 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury
(Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Motorcycle 5 Pending Natural 1 Yes 2 No death. М 2 Accident investigation Director: / involved in collision 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) building, etc. (Specify)

Sheet

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 4 Homicide within 24 hours a 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. August 06, 2004 Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 6 KONI

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

AUG1 1 2004

rocker

32 Registrar's Signature

IVAN W. DESKINS Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item #23a, 27, per MB, G834, 8/2//04 TT
State of Maryland / Department of Health and Mental Hygiene 04-05169 RKD For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9 2004 ar AUGUST Physician 1:45P. Ivan Wayne Deskins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CECIL CHARLESTOWN 712 OGLE STREET If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Nov. 12, 9. Birthplace (State or Foreign 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Days 1**№** M 2□F Maryland 47 Yrs. 1956 214 72 1152 Nov. Director Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28e-f show the Medical Exercises must be notified at 1 Tyes 2X No Charlestown Director Cecil Maryland the ! 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 U.S. 21914 Items 23e 712 Ogle Street death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2 🙀 No Yes, Give 1 X Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: δ 3 Widowed 4 Divorced Year or Dates 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Miller Mechanic 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be find and Mental H Rose Youngbar Ivan Kellous Deskins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s if Health an item 27 ls r Rising Sun, Maryland 21911 51 Sunrise Drive Ivan K. Deskins / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott Burial 2 ☐ Cremation 3 ☐ Removal from State 8/12/2004 Baltimore, Maryland Cedar Hill Cemetery ^ 4 ☐ Donation — 5 ☐ Other (Specify) 21. Signature of Scheral Service Life 22. Name and Address of Facility Gonce Funeral Service, P.A. once. enc 23a. Part. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arterioscleroticcardiovascular disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or Janying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day ō 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed certificate 2☐No Yas 2 No Yes Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1XYes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide ō within 24 hours at To the Funerel D completely filled in Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only ogel and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and til AUGUST 10,2004 O.C.M.E.

State
Registrar

30. Name

ORIGINAL

Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)
111 Penn Street, Baltimore, Maryland 21201

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			For Stata Registrar	State of M	larylan		artmen <i>rtificat</i>				•	giene Reg. No	001	
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Di	s afte	Certification;	4 ☐ Homicide determined	building, e	itc. (Specif	y)					City or To	wn, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier (Check only one) Certifying Property 2 Medical Example 1	nysician: To the best miner: On the basis of and manner s	of examina	wledge, death	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)
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-	0		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)				1		1	,
			DR · KOMAZ D 31. Date filed (Month, Day, Year)	AN REA	عري	31	NA	1 11	059	ITA	- OF	86	7471	MORE
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Clara Diggs 1020 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris-Mercy Baltimore NA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 □ M 3 □ F Yrs. 216-34-9439 Director 66 Md Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show treumatic avant, the Medical Examinar must be notified at 1X Yes 2 □ No Md. NA Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4607 Simms Ave 21206 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married Marylahá 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within ; th and Mental Hygiene. 7 Is marked other than "r Correction Elementary/Secondary (0-12) College (1-4or 5+) Md. State Division of llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be mit. Pages 1 and 2 should be partment of Health and Menta portant: If item 27 is marked y injury or othar treumatic an Lopez Bernice Jose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4607 Simms Ave., Baltimore, Md. Friend Joshua J. Harkness Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 8-10-04 Garrison Forest Vet. Owings Mills, Md. A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. H la Wa March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nacrentic conce Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
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النب		For State Registrar		ryland / Depa <i>Ce</i>	rtificate of Death	, ,	Reg. No?	25205
		Decedent's Name (First, Middle, La	st)			2. Date of Dea	ith	3. Time of Death
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if Health and Meritem 27 is market other treumatic		Harry R. Dawson 20a. Method of Disposition	(son)	20b. Place of Dispo	esition (Name of		20c. Location - City or	Town State
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niur)		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Light		Holly Hi	11 Mem. Gdns. 08	3/09/2004 Juda=Ruck	Middle Rive	er, MD.
Department of He importent: If item any injury or other once.		21. Oightfure of Funeral Service Ed.	1		922 Wise Ave. Du			
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			Registrar 1. Decedent's Name (First, Middle, Last,			timeate of t	Dealit	2. Date of Death	ng. No.	3. Time of Death
	Physici		Christina Lu	on Davil	И			AMonth	Day Year	L MULICAM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	<i>F</i> \	4b. City, Town, or	r Location of Death	· ioagus	4c. County of Deat	h 941424
	LXamii		The Johns Ho	Oline Hoso	ital	Baltimo	10 0:	Ly	, , , , ,	
	Funeral		Social Security Number 6. Security Number		. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign untry)
	Director		none 10]M 2X0F	Yrs.	Months Days	Hours Min.	(Month, Day, July 22		vland
	DE .		Usual Residence of Decedent 10a. State 10b. County	100.6	ity, Town or Lo			4		
	ehovia	5	,		•					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	be filed within 72 hours efter death with the Maryland stal Hyglene. id other than "natural", or itema 23a or 28a-f ehow event, the Medical Examinar must be notified at	급	650 Jennifer Lan	e		10f. Zip Code 21(001		og. Citizen of What Co USA	untry?
	na 23	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	1		cify Yes or No-	14. Race - Ame	rican Indian
(0)	riter of	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No			ispanic Origin? (Spe an, Mexican, Puerto I	Rican, etc.)	Black, Whit	
93	ral', c	ģ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: Wh	ite
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Maryland	should be filed nd Mental Hygi marked other imatic event, I	Be	Robert Allan Da				18. Mother's Name		-	
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Za	2 4 9 8		Erin J. Comeau - M						aryland 21	
ē,	other tr		20a. Method of Disposition	20b.		osition (Name of matory or other place			20c. Location - City or	
9	90=5		1 ☐ Burial 2 ☑ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	idilloval Itolii State			corp. 8-9-	.04	Towson, Ma	rarl and
Baltimore,	그 문문을		21. Signature of Funeral Service Licens						neral Home	
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			23a. Part 1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the dea						Approximate Interval Between
	Pnysician:		Immediate Cause (Final disease or condition	Rioth	ASO	huria				Onset and Death
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Вох	death certifice attending ph for use as t	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prega					23d. Date of del	iverv
Ä.	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fel 4□Pregnant at time of		⊒Ectopic pregnancy ☐ Other <i>(specify)</i>			Month	Day Year
P.0	that the de led by the a deteched t	hys	9 □ Unknown	9□ Unknown						
	8 5 6	by F	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	w requir been sl should l							1 🗆 Ye	s 2 No 3 Pr	obabiy 4 Unknown
ec	e law r hes bu	Completed						24a. Was ar autopsy	y prior to	topsy findings available completion of cause of
E B	60	Con						perform 1 Yes 2	ed? death? No 1 ☐ Yes	_
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on	ding I h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No	280. Describe 110	w injury occurred	
Division	or Attendin efter death. Director: Att In by the fur	fica	3 Suicide 6 Could not be	28e. Place of Injury - At	home, farm, st			28f. Location (Str	reet and Number or Ru	ıral Route Number.
á	el or A s efter il Dire id in by	Certification;	4 Homicide	building, etc. (Spec				City or Town	, State)	
	ospit hours uners ly fille		29a. Certifier Certifying Phy	sician: To the best of my kr ner: On the basis of examin	nowledge, deat	h occurred at the tin	ne, date and place, a	and due to the ca	use(s) and manner as	stated.
	To the Hospitel or Attending Physician: within 24 hours effector; After this certific to the Funeral Director; After this certific completely filled in by the funeral director.	ledical	Oney	and manner stated.	ation and/or in					
	To Toon	Σ	29b. Signature and title of certifier	- 100		29c. Licens			9d. Date signed (Mont	
,			cum but	2111			-000	A	ugust 7,	2004
1			FRIN VISH 60	ompleted cause of death (Ite	эт 23a) (Турв,		440 7176		(195)	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	althore	MD 2128	7 300		
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3^{Day} 2004 **Physician** August 8, 7:05 am M Claire Edith Franklin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore Towson Hours Min. July 29, 19 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕅 F Months 79 Director 217-40-0640 England Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic evant, the Medical Evantier must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 B Springhead Court 21030 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 2**X** No Yes, Give 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene ortant: if Item 27 is marked other than 'injury or other traumatic evant, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 -0-Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas Michael Rourke Norah Agnes Hawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Margate Road, Lutherville, MD John Franklin (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial ACCremation 3 Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Aug. 11, 2004 Baltimore, Maryland Chisholm Funeral Services of Dulaney Valley, P.A. 21. Signature of Experal Service Licensee 200 E. Padonia Road, Timonium, MD 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician thalamic hemorrhage days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by breast cancer 1 Yes 2 No 3 Probably 4 Vinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an director, page 2 autopsy 2 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗍 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MA DS0800 112ell-30. Name and address of person who completed cause of death (Item 23a) (Type, Print Baltimole MD 21204 rarles DeMusis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar vacks AULL 1 ZUU4

		_	For State Registrar		e of Mar	yland /		artmen rtificate			and M	lental Hy	Reg. No		di ann	2520)
	Physici	30	Decedent's Name (First, Midd									2. Date of De Month	aath Day	, O O \	ear	3. Time of Deat	ì
	/Medic		BEATRIC		GEE	ORG	F					AUG	800			9.408	М
	Examin	er	4a. Facility Name (If not institution	_						Location of	of Death			County of			
			Brightwood G					Lut If Under		/ille	24 Hre	0 Date (D)		Balt	7m	ore	
	Funeral		5. Social Security Number 176–18–6785	6. Sex 1 ☐ M 24∑		(In yrs. last 82	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di 9/21/	rtn a <i>y, Year)</i> 1 O O 1		9. Birth; Coul	place (State or Fore	ign
	Director		Usual Residence of Decedent				.,,,,,					9/21/.	1921		PHII	L. PA	
	/iand		10a. State 10b. County		1	10c. City, To	own or Lo	cation							1	10d. Inside City Lin	nits
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	deat deat	Funeral Director	11. Marital Status	12. Was	Decedent Eved Forces?	rer in U.S.	13.	Was Deced				ecify Yes or Na Rican, etc.)	0-		Americ White,	can Indian,	
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5-0036	72 hours effer death with the Maryland naturel; or iteme 23e or 28e-f ehow dical Examinar must be notified at	d b	3 X Vidowed 4 □ Divorce	Year	or Dates:												
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121	Parithir	Ę	Elementary/Secondary (0-12) 12	Colle	ege (1-4or 5+))		300KKI					T	RETAI	т.		
d 21	Hygid ther		17. Father's Name (First, Middle)	Last)				JOOKKI	101		r's Name	e (First, Middle					
a	d be enter	To Be	William F.								Mae	C. McCa	au1ev	7			
Maryland	Shout mari	۲	19a. Informant's Name/Relation		r)	1	19b. Mailir	ng Address	(Street a			al Route Numb			tate, Zin	Code)	
Z	27 le		Jackie Geor	ge			1609	Falls	ston	Road	, Fa	llston	, MD	2104	7		
5	tem tem othe		20a. Method of Disposition			20b. Place	of Dispo	sition (Nan	ne of	a)	1	Date	20c. Lo	cation - C	ity or To	own, State	
Ę	Page ento nt: ∺ ry or		1 XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (from State			oulchi			8/12	/2004	СН	ELTEN	HAM	TWP., PA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Meniel Hyglene. Inportent: If item 27 is marked other than "naturel; or items 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinat must be notified at ance.	1	21. Signature of Furieral Service		70			2. Na <i>m</i> e an		-		FINK					
m	20 E 2 8		kelly Greg		k #MO1	148	1	426 CI	RAIN	HIGH	WAY					21061	
	/Medical Examiner	Examiner	23a. Part1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	a	RICO ue to (or as a	consequent	COW ce of): 20 kg ce of):	ER	Los	E PI	VEL	NON CUS				Approximate Interval Between Onset and Death	
P.O. Box 68780	res that the death certificets be executed igned by the attending physician and be detached for use as the buriel-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2'⊡ No 9 □ Unknown	101 401	s, outcome of Live birth 2 Pregnant at ti Unknown	☐Fetel de	ath 3	■Ectopic pr Other (sp						23d. Date Mont		ery Day Year	
	s than	by P	Part II. Other significant condit	ions contributing	to death but	not resultin	g in the u	nderlying c	ause give	n in Part I		23e. Did	tobacco u	ise contrib	ute to t	he cause of death?	
ğ	w requires t been signe should be	pe										10	Yes 2	□No 3	Prob	oably 4 Unkno	WΠ
of Vital Records,	e law	Completed										24a. Was auto perf 1 \(\text{Yes}		pri de	or to co ath?	psy findings availa mpletion of cause	ble of
ita	ilclen: Th certificate rector, peg	Be C	25. Was case referred to medical examiner?	al						26. Place	of Deatl	n (Check only		1			
>	\$ ∞ ₹	10	1 ☐ Yes 2 ☐ 1√10	Hospital:	1 Inpatient	t 2□ER	Outpatier	nt 3 DC	A Othe	er: 4 0 Nu	irsing Ho	me 5□Res	idence	6 □Other	(Specif	'y)	
ion o	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral			igation	Date of Injury (Month, Day	Year) 28	b. Time of Injury	f 2	8c. Injury Work			28d. Describe					
Division	s after designation of the state of the stat	Certific	3 Suicide 6 Could 4 Homicide deten	nined 286.	Place of Injury building, etc.	y - At home (Specify)	, farm, str	eet, factory	, office			28f. Location City or To	(Street an wn, State	d Number)	or Rura	al Route Number,	
	ne Hospit 24 hour ne Funer detely fille	Medical Certification:	29a. Certifier 1 Certifyi (Check only 2 Medica		the basis of e manner state	xamination ed.	and/or in	vestigation,	in my o	oinion, dea	th occurr	red at the time	date and	place, an	d due te	the cause(s)	
	To the To the To the To the To the Comp.	ž	29b. Signature and title of certifi	Br				290	. License	number			29d. Da	e signed	Month,	Day, Year)	
			San	He M.	D			D	was	315	V		AUC	190	F) 2	2009	
	16		30. Name and address of person	who completed	cause of dea	ath (Item 23	la) (Type,	Print)		<u> </u>				<u> </u>	ME	RVILLE	
	(U		SHAKUNMAL	A GU	PTA M	10	51	5 BR	16-	HTF	131	D RC	20		ME	2109	3
	Sta Registi		31. Date filed (Month, Day, Year AUG 1 1 200	4 4	32. Registrar	's Signature	4	oux.								Day, Year) 2009 RMILE 07109	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** James Foster Galloway /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SACred ALLeGAN umberland NEART If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) XXM 2□F Months Director 577-92-9690 Japan Usual Residence of Decedent the Maryland works 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or items 23a or 28e-f showing Wedical Examinar must be notified at 1 ☐ Yes 2 ☐ No Garrett Director Maryland Grandsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 193 Main Street 21596 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ☐ Yes 2XXNo Maryland 21215-0036 1 ☐ Yes 2☐No Specify: δ Specify: 3 Widowed 4 Divorced **Black** Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Sales Representative Communications es 1 and 2 should be filed vot Health and Mental Hygie of Health and Mental Hygie of fitem 27 Is marked other to other treumatic event, In other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Anthony Galloway 2 Ruth Ann Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 Is or other tree Jerry A. Galloway / Father 9216 Dandelion Lane Upper Marlboro, Maryland 20772 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of mportent: If any injury of one of the order. ` 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem'l. Cem. 08/09/2004 Suitland, Maryland 22. Name and AddresGebailty P. Kalas Funeral Home PA 21. Signature uneral Service Licensee other 6160 Oxon Hill Road Oxon Hill, Maryland <u> 20745</u> 23a. Part1. Intel the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ATED ARDIOMYOP Two Years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ASXS TOLE ONE DAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine BRONCHITIS death certificate be executed use as the burial-transit ASTIMATIC ONE WEEK that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. ONE MONTH Physician/Medical Duy 2, 2009 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 Pregnant at time of death P.O. I 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 2 signed d be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ ATRIAL FIBRILLATION cate has been signated by page 2 should b 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed DEFIBRILLATOR 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No 1 Yes 2 X No 25. Was case referred to medical examiner? (∠ L & 4) 1 ▼ Yes 2 □ No funeral director. 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ € ROutpatient 3 ☐ DOA Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funerel Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined ō Fo the Hospitel 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Sabahal MN MD005865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 265, GRANTSVILE corporate DR. NAWAB, SABAHAT 31. Date filed (Month, Day, Year) AUG 1 32. Registrar's Signature State 1 2004 Registra

hysician		Registrar 1. Decedent's Name (First, Middle, La	st)		rtificate	OI L	Joann	- 1	2. Date of Dea			3. Time of Death
		JOHN ARTHUR G	RAY. SR.						Month AUGUST	Day 6 2	Year 2004	11:30 A.
Medica/ Examine		a. Facility Name (If not institution, given			4b. City, 1	Town, or	Location o	f Death	HOGODI		ounty of Deat	
		4922 BRIGHTLEAF					MARS				ALTIMO	
uneral rector		5. Social Security Number 6. S 081-07-5646 Usual Residence of Decedent		n yrs. last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birt. (Month, Day 01/26/	1917	9. Bird Co NEW	hplace (State or Forei ountry) YORK
M TI	-	10a. State 10b. County	10	Oc. City, Town or Lo	ocation							10d. Inside City Limi
r 28a-f show	į	MD BALTIM	ORE	WHITE I	MARSH							1 ☐ Yes 2 ☐ X
or 28	Director	10e, Street and Number			10f. Zip	Code				10g. Citize	n of What Co	ountry?
		4922 BRIGHTLEAF	COURT			1237				UŞA		
Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decede If Yes, spec	lent of His lify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	14	I. Race - Ame Black, Whit	
	2	3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates: WW	'II	1 ☐ Yes 2	2X No	Specify:			s	Specify: WI	HITE
"natural"	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usua kind of wor	I Occupa	tion	of working	200	16b. Kind	d of Business/	Industry
	ig -	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	e retired)	1	O, NOIAN	.g			
othar than	<u> </u>	12TH GRADE 17. Father's Name (First, Middle, Last)	SAL	ESMAN	-	18 Mothe	r'e Name	(First, Middle.		USTRIAL	
2 8 5	ň	JOHN F. GRAY	,							Maiden S	umame)	
EE	0	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ing Address	(Street a			HUGHES I Route Numbe	r. City or 1	Town, State, 2	Zip Code)
SA P		AGNES B. GRAY	WIFE	1 .	BRIGH				BALTIM	-		1237
item 27 othar tra	ı	20a. Method of Disposition	4	20b. Place of Dispo cemetery, cre	osition (Nam	ne of	1		ate		ation - City or	
int: If		1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci	Removal from State	ST. MARY!	-			3/12/	/2004	BETH	EL, CI	
Important: If ite any injury or of ODCE.	1	21. Signature of Funeral Service Lice							_			HOME, P.A.
E & 8	37	1							VD. TO			21286
/sicia	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACUT	ysplasia onsequence of,	ELO	011		LET	I KEM	II.A		Iniérval Between Onset and Death 2 imoustus
by the attending phy tached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					23	ld. Date of del Month	ivery Day Year
signed t	d by P	Part II. Other significant conditions Hypertension, A		-	, ,		n in Part I.			bacco use		the cause of death?
s been sign	lete	Disease							24a. Was	an	24b. Were au	topsy findings availab
	Completed								autop	SV	prior to death?	completion of cause of
age age		25. Was case referred to medical					26. Place	of Death	1 Yes	,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	SKNO
rtificate has	ē	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DO	A Othe			ne 5 Resid		☐Other (Spec	cify)
rector	n	1 ☐ Yes 2 🗙 No		28b. Time o	of 28	8c. Injury Work	at ?	2	28d. Describe h	ow injury	occurred	
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fter this certifi	10 B	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	on 200 Plans of Injury	- At home, farm, st	М	1 🗆 Y	05 2,0,	2	28f. Location (S City or Tow	street and i	Number or Ru	ıral Route Number,
fter this certifi	Certification; To B	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28e. Place of Injury building, etc. (- At home, farm, st Specify)	M treet, factory	1 🔲 Y	e date and	d place, a	City or Tow	m, State)	nd manner as	etatad
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DHMH 17 Rev 1/2001

ORIGINAL

		Please	State of Ma	aryland /	/ Departm	ent of H	lealth and M	lental Hyg	giene		
	_1	- State Registrar			Certific	ate of L	Death		Reg. No.	2004	2521
Physicia /Medic	ın	Decedent's Name (First, Middle, La LELAND GAY HILE						2. Date of Dea Month	Day	Year 2004	3: Time of Death
Examine		4a. Facility Name (If not institution, gir	ve street and number)		4b. (City, Town, or	Location of Death		4c. (County of Death	
		6865 Old Waterlo				lkridge				oward	
Funeral Director		234-66-7651	Sex 7. Ag 1 M 2 F X	63	Yrs. Mon	nder 1 Year ths Days	Hours Min.	8. Date of Birth (Month, Day DFC 28	y, Year)		place (State or Forei intry) Virginia
and	-	Usuel Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location						10d. Inside City Limit
Maryl f sho	ğ	MD Howard		Elkr:	idae						1 ☐ Yes 3€
72 hours after death with the Maryland naturel, or Items 23e or 28e-f show dical Examination usite multified at	Director	10e. Street and Number				. Zip Code	_ -		10g. Citiz	zen of What Cou	intry?
th wit	E C	6865 Old Waterlo	o Rd., Apt	. 1814		21075				USA	
or dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. Was D If Yes,	ecedent of Hi specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 	
, or it	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	No CO C	1 🗆 Y	es 2 No	Specify:			Specify: wh	nite
s I and 2 should be lied within 72 hours after death with the warylar if Health and Mental Hygiene. I then 27 is marked other than "natural", or tems 23s or 28s-f show tem 27 is marked other than "natural", or thems 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	ed t	15. Decedent's E			6a. Decedent's	Usual Occup	ation		16b. Kin	nd of Business/I	
within 72 ene. then "ne	piet	(Specify only highest gi	rade completed) College (1-4or 5	i+)	(Give kind o	of work done of OT use retired	during most of work 1)	ing			
Hygiene.	Completed	12	00.000	,,	Service	Techn	ician		AD	T Secur	ity
tal Hygi d other	Be	17. Father's Name (First, Middle, Las					18. Mother's Name				
should be to ind Mental to marked of umatic eve	ဂ္	Troy B. Hileman						Jane Be			
h and 7 is m raum		19a. Informant's Name/Relationship	(Type, Print)				and Number or Rur				_
Healt Healt hm 2 ther		Linda Staddon 20a. Method of Disposition		20b. Place	e of Disposition	(Name of		Date W		1 • 2650 cation - City or 1	
Pages nent of nt: if it iry or o		1 XBurial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Spec			etery, crematory View Ce			/2004			lls, W. V
그 본 원 중		21. Signature of Funeral Service Lice		rall	22. Nam	ne and Addres	ss of Facility				
Depa Impo		M. Poh			Gary 7250	L. Kau	ifman Fune	eral Hom	e@M	MD 2	dge MP, In 1075
44		23a. Pert1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death. [7	Approximate Interval Between
hysician		Immediate Cause (Final disease or condition	Com	Mhy	Auto	Lace .	isense.				Onset and Death
/Medical		resulting in death)	a. Due to (or as	a con Juen	nce of):	7	/ Incacac				
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Sit 90	iner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ice of):						
and -tran	Exan iner	that initiated events resulting in death) Last	c Due to (or as	a consequen	nce of):						
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certificate Iding phys			d								
leath certificate to attending physical for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			pic pregnancy	,		2	3d. Date of deli	very
0 0 0	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant a			or (specify)	·			Month	Day Year
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igned k	by	Part II. Other significant conditions	contributing to death t	out not resultir	ng in the underly	ring cause giv	en in Part I.			-	the cause of death?
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has b	Completed							24a. Was autop		24b. Were aut prior to c death?	opsy findings availal ompletion of cause o
(G) L								1 ☐ Yes	2 No		2□ No
ysician: Th	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Deat				_
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ding I h. After funer		1 Natural 5 Pending	(Month, Da	y Year)	Injury	28c. Injur Wor	k?` Yes 2□No		,,,,,,,	,	
V + -	tlor			jury - At home	e, farm, street, f	actory, office		28f. Location (S City or Tox	Street and	d Number or Ru	ral Route Number.
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tal or Attences after death	Certification	2 Accident Investigati 3 Suicide 6 Could not	d 286. Place of in	tc. (Specity)							
Hospital or Attend 24 hours after death Funeral Director: stely filled in by the t	dical Certification;	2 Accident investigati 3 Suicide 6 Could not determine	building, e Physician: To the best	of my knowle	edge, death occi n and/or investig	urred at the tir jation, in my o	те, date and place, ppinion, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
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To the Hospital or Attent within 24 hours after doors after Drector: To the Funeral Director: completely filled in by the t	edical	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier Check only one)	Physician: To the best aminer: On the basis of and manner st	of my knowled examination ated.	n and/or investig	29c. Licens	pinion, death occur se number	red at the time,	date and	place, and due e signed (Montt	to the cause(s)

		•	For State Registrar	State of Maryland		artment of h		nd Mental H	ygiene Reg. No	Z 11 11 15	25212
			Decedent's Name (First, Middle, La	ast)				2. Date of I	Death		3. Time of Death
	Physicia		Sherman	L. Harve	ev			AUGUS'	Dа Г 06	y Year 2004	1726 ^M
	/Medic Examin	460	4a. Facility Name (If not institution, gi			4b. City, Town, o	or Location of			. County of Dea	
			MALCOLM GROW MED	OICAL CENTER		ANDREWS		ARYLAND_	PR	INCE GE	
9	Funeral	100	,	Sex 7. Age (In yrs. &		If Under 1 Year Months Days		Min. (Month,	Day, Year)	9. Bi	rthplace (State or Foreign country)
	Director		425-64-9030	68	Yrs.			08/25	/1935	Mı	ssissippi
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Mary	ţ	MD P.G.	Ft.	Wash	ington					1X Yes 2 □ No
	7.28a	iec ec	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What C	Country?
	death with the Maryland	a D	512 Hadrian La	ne		2	0744		U.S	. A .	
0000	within 72 hours after death with the Marylan ene. Than "natural", or items 23a or 28a-1 show the Madical Examination insulate indiffied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1√2 Yes 2 □ No If Yes, Give Year or Dates:	1	Was Decedent of I If Yes, specify Cub 1 ☐ Yes ŽOŇo		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Wh BI Specify:	
ş	tura stura		15. Decedent's E		16a. Dece	dent's Usual Occu	pation		16b. h	Kind of Busines	s/industry
0	o u	Completed	(Specify only highest go	rade completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most o	of working			
7	e filed within al Hygiene. I other than ' vent, Ine Ma	E	Elementary/Secondary (0-12)	4 Years	DC P	olice C	ffice	r	DC	Govern	nent
2	be file tal Hy d othe	an i	17. Father's Name (First, Middle, Las					s Name (First, Midd	de, Maidei	n Sumame)	
yland	should be nd Menta marked umatic ev	To Be	John H. Harvey					Smith			
ā	. a . a		19a. Informant's Name/Relationship Armentha S. Ha					or Rural Route Nur.			
nore	eges 1 and 2 ant of Health ht: If item 27 l y or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec			osition (Name of matory or other plate e Crema		Date 8/12/04		ocation - City o $ m erdale$	
Бащто	permit. Peges 1 Department of H Important: If ite any injury or ot once.		21. Signature of Fueeral Service Lice	1	2:	2. Name and Addr	ess of Facility	Austin	Roy	ster E	Funeral Hom
	4		23a. Part1. Enter the disease, or con	mplications that caused the death				N.W. W		0011	Approximate
	Obvoision		shock, or heart ailure. List ont								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ARRYTHMIA Due to (or as a consequ	uence of):						2 minutes
	Examiner			MERA CRATE		ATE CANC	FR				3 years
ı.		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. METASTATIC Due to (or as a consequence)		ALL CANO	LIX.			·····	J years
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
	ate b hysic the b	lical	•	d							
RG X	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	nocy					201 5 11 11	(-B
ХOЯ	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal	I death 3[☐Ectopic pregnand ☐ Other (specify)	Э			23d. Date of d Month	Day Year
o.		ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	eath 5t	_ Other (specify)			-		
1	5 2 2	Y P	Part II. Other significant conditions	contributing to death but not res	ulting in the u	inderlying cause g	ven in Part I.	23e. D	id tobacco	use contribute	to the cause of death?
Vital Records,	w requires t been signe should be	d by						1	☐ Yes 2	2 □ No 3 □	Probably 4Unknown
ဂ	w req	lete						24a. W	as an	24b. Were	autopsy findings available
Ř	he las e has age 2	Completed						at pe	utopsy arformed? s 2∰N	i prior te	o completion of cause of
ta		Be C	25. Was case referred to medical				26. Place	1 ☐ Ye of Death (Check on		10 Y	es 2□No
5	Physician: r this certific ral director.	To B	examiner? 1 ☐ Yes 2 2 No	Hospital: 1 Hopatient 2	ER/Outpatie	nt 3 DOA	ther: 4 Nur	sing Home 5 R	esidence	6 ☐Other (Sp	pecify)
0 00	ding Ph. h. After thi funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 28c. Inju		28d. Descri		ury occurred	
Division of	or Attendater deatl Director: in by the	Certification:	3 Suicide 6 Could not determine		ome, farm, st	treet, factory, office)		n (Street a Town, Sta		Rural Route Number,
_	Hospitel 4 hours Funeral ely filled	edical Co	(Check only 2 Medical Ex	Physician: To the best of my kno aminer: On the basis of examina	wledge, dea	th occurred at the	time, date and	place, and due to the courred at the tin	the cause(s) and manner nd place, and d	as stated. ue to the cause(s)
	To the within 2 To the Complet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licer	se number	[HD] HN	29d. D	ate signed (Mo	enth, Day, Year)
)	7 ≥ T ⊗					1	5521	•	176	406,0L	
			30. Name and address of person wh	no nomploted saves of death flori	n 03c) (T =		111	011/	1 , ,	- 070	J
0			Barbara Ann Co				Manul	and 207	62		
	St	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	time V	1 Ann	Nary I	and 207	04		
	Regist	tar	AUG 1 1	2004	~	July					

DHMH 17 Rev 1/2001

Barbara Ann Cooper, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar	State of Maryland /	Department of Certificate			ene a. N2 0 0 L	25213
Physician /Medical		THORNE			2. Date of Death Month 08 - 05	Day Year	3. Time of Death 8:49 AM
Examiner Funeral	4a. Facility Name (If not institution, give sit 30) MC MECHEN 5. Social Security Number 6. Sex	ST. # 1016 7. Age (In yrs. last bi	BALT	vn, or Location of Death IMORE fear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Death NA 9. Birth Cou	place (State or Foreign
Director	Usual Residence of Decedent 10a. State 10b. County	64	Yrs.		01.06.1	440	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show rmust be notified at an erail Director	MD NA	BALTI	MORE 10f. Zip Co	de	100	g. Citizen of What Cou	1 Yes 2 No
	301 MC MECHEN 11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces?	21 13. Was Decedent If Yes, specify	217 of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
5-0036 72 hours after neturel; or its dical Examine steed by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🖪	No Specify:		Spanifu:	ACK
d 21215-00 d 21215-00 lited within 72 hou thygiene. Then then "neuture ont, the Medical E Completed	(Specify only highest grade Elementary/Secondary (0-12) 12 TH GRACE	College (1,4or 5+)	(Give kind of work d life. DO NOT use n JANTORIA	one during most of work etired)	ang	3ETHLEHE	
d be til	17. Father's Name (First, Middle, Last) OSCAR HAWTHORN			EDMH S	e (First, Middle, Ma SINGLET	DN	
re, Maryl re, Maryl rand 2 shoul Health end M rem 27 is mark	ANIOLNETE HAW 20a. Method of Disposition	MHORNE 12			J., BAU	Dity or Town, State, Zip Oc. Location - City or To	1229
timo trimento rant: If	1 ☐ Buriat 2 【Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice	GREEN	JMOUNT	ddrass of English	2.04 B	ALTO-MD	
Bal Berni Departi Impo Impo any ir	23a. Part 1. Ent or the disease, or complic shock, or he in failure. List only one	cations that caused the death. Do	15151 BAL not enter the mode of	C. GREEN 1 70. NATU PIK dying, such as cardiac	E BADO. or respiratory arres	1, 140 21225	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Atherosclero Due to (or as a consequence End Stage	otic Can	dio vasco	ular D.	ismse	Onset and Death Un Know/
60, be executed cien end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a consequence	of):	1 1)150	use		
Records, P.O. Box 6876 The law requires that the death certificate be title has been signed by the attending physicionage 2 should be detached for use as the buse.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregn 5 □ Other (specif			23d. Date of delive Month	ery Day Year
	Part II. Other significant conditions cont		in the underlying caus	e given in Part I.	1 🗆 Yes	cco use contribute to the	pably 4 nknown
	25. Was case referred to medical			26 Place of Death	24a. Was an autopsy performe 1 Yes 2	Drior to co	psy findings available mpletion of cause of 2000
To To	examiner? 1 Yes 3 No Ho 27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury 28b.		Other: 4 Nursing Ho		ce 6 Other (Specifinjury occurred	y)
Division of Division of State of Attending Formal Director: After filled in by the funeral Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, S		
o the Hosp ithin 24 hou o the Fune ompletely fil	29a. Certifier (Check only one) 2 Medical Exemination (Check only one)	ician: To the best of my knowledger: On the basis of examination are and manner stated.	nd/or investigation, in i	ne time, date and place, my opinion, death occurr cense number	red at the time, date	se(s) and manner as s and place, and due to I. Date signed (Month,	the cause(s)
F358	Kennet	nple indicause of death (Item 23a)	no o	47089		P/10/0.	
State Registrar	31. Date filed (Month, Day, Year) AUG 1 1 200	32. Registrar's Signature	A /		_		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / t	Department of Health and I Certificate of Death	Mental Hygler Reg. l	A				
			Decedent's Name (First, Middle, Last)	2. Dete of Deeth	3. Time of Death					
and the second	Physicia /Medic		WILLIAM J. HENDER SO	NC	JULY 2	7 2004 0750				
e de	Examin		4a Fecility Name (If not institution, give street end number)	4b. City, Town, or i		4c. County of Death				
	*			CENTER BEL	AIK	HARFORD				
	Funeral Director			Yrs. Months Deys Hours Min.		9. Birthplece (State or Foreign Country) Mass				
	dand		10a. Stete 10b. County 10c. City, Town or Location 10d. Inside C							
	Many P-f sh	ţ	MD Harford 1	Darlington		1 □ Yes artino				
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?				
	ath wi	ral	4303 Conowingo Road	21034		USA				
20	be filed within 72 hours effer death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Midowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Ves 2 □ No If Ves Give Year or Dates: ₩₩ 2	13. Was Decedent of Hispenic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes ②♥♥ Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
9	2 hou	B	15. Decedent's Education 16e.	. Decedent's Usual Occupation	16b.	Kind of Business/Industry				
Maryland 21215-0020	filed within 7. Hygiene. ther then "ru	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired) Carpenter	rking	ome builder				
þ	0 = 0 2	Be C	17. Fether's Name (First, Middle, Last)		me (First, Middle, Maid					
ylaı	should be and Mental I marked or umatic eve	2	William J. Henderson	Berth	a Doell					
Mar	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationship (Type, Print) Robert S. Henderson -brother	Mailing Address (Street and Number or Ru						
	leaf		20a. Method of Disposition 20b. Place 9	of Disposition (Name of		A U1 / / 3 Location - City or Town, State				
E O			1 Rurial 2 Peremetion 3 Removal from State Cemete	ny, crematory or other place) s Eagle Crematory						
Baltimore,	permit. Page Depertment of Important: if any injury or once.		21. Signature of Funeral Service Licensee	zz. Name and Address of Facility		17314				
		\dashv	23a. P. rt1. Enter the disease, r complications that caused the leath. Do nock, or heart failure. List only one cause on each line.	Harkins F.H.Inc.		Approximate				
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) a. Myocarda Due to (or es a	at infantion consequence of: otic Cardiovas consequence of:	culon	Intervat Between Onset and Death				
ox 68760,	tificete be ig physicia es the bur	Medicai	if eny, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury c	consequence of):						
. Box	death cert e ettending d for use o	icia	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I	23h Did tohac	co use contribute to the cause of death?				
, P.O	es that the de igned by the e be deteched t	by Physician/	Hypertension Hype	The rordism	1 ☐ Yes	10				
of Vital Records,	requir been s should	Completed	Heart Pauline	/. 	24a. Was an autopsy performed? 24b. Were autopsy findir available prior to completion of cause of death?					
Ä	The law sete has page 2	E O	COPR		1 ☐ Yes	2 No 1 □ Yes 2 No				
/ita	ilclan: Th	Be (Ayaminer/		ath (Check only one)					
of \	97	2			lome 5 Residence					
ion	After fune	ation	27. Manner of Deeth 1 Naturel 5 Pending (Month, Dey Year) 2 Accident investigation	jury occurred						
Division	al or Atta s efter de ni Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	28f. Location (Street City or Town, St	on (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or Attand within 24 hours effer death To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 ☐, Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu	o, and due to the cause irred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)				
	To the Within 2 To the	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)							
	•		Blinax & Juha MD DAE	120014206	Je.	l, 28, 2004				
i))		30. Name end eddress of person who completed cause of death (Item 23a)	(Type, Print) FUABIRD	AVE RA	170 MH 21222				
j. 5	Sta	te	31. Date fited (Month, Day, Year) AUG 1 1 2004 32. Registrar's Signature	& how V	ni- DN	10 16 2122				

Patient Known as Harnet Horton
Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Please	Type or Prin		ndelible Ink. partment of F		•	_	ble.	
		1 - For State Registrar	Oldio of Me		ertificate of		, ,	leg. No. 1	11. 25215	
Physicia /Medic		1. Decedent's Name (First, Middle, La	Horton	2			2. Date of Dea Month	Day	Year 2004 04109 AM	
Examin	er	4a. Eacility Name (If not institution, giv		Simore	4b. City, Town, o	r Location of Death	4.	4c. County		
Funeral Director		5. Social Security Number 6. S 212-48-9741		(In yrs. last birthda 56 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 10/03/19	, _{Year)}	9. Birthplace (State or Foreign Country) MD	
yland sow		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town or	Location				10d. Inside City Limits	
ath with the Marylan 23a or 28e-f show	Director	MD BALTIMO	RE	WOODSTOC					1 □ Yes 2 No	
3a or 2		10e. Street and Number 2503 OFFUTT ROAD			10f. Zip Code 21163		1	10g. Citizen of V U.S.A.	Vhat Country?	
urs after de	by Funer	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	1	3. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race	e - American Indian, k, White, etc. WHITE	
within 72 hours ane. then "naturel"	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		+) (Gi	cedent's Usual Occup ve kind of work done of DO NOT use retired	during most of work d)		JOHNS H		
permit. Pages 1 and 2 should be filed within Deportment of Health and Mental Hygiene Importent: If Item 27 is marked other then any injury or other treumetic event, ITEM 2006.	To Be Co	17. Father's Name (First, Middle, Last, HENRY)	Abiiii	FOX	18. Mother's Nam				
nd 2 sho lth and I 27 is me		19a. Informant's Name/Relationship (Туре, Print) USBAND		OFFUTT RD			•	State, Zip Code)	
iges 1 ar at of Hea if Item or other		20a. Method of Disposition X Burial 2 Cremation 3	Removal from State	20b. Place of Dis cemetery, co	position (Name of rematory or other place	ce)	Date	20c. Location -	City or Town, State	
mit. Pa Dertmer Sortent / Injury		`4 □ Donation 6 □ Other (Special 21. Signature → uneral Service Live	(y) (see	CHIZUK AM	UNO CONG. 22. Name and Addre	08/08/ ss of Facility SOI		ALTIMOR		
permi Depe Impo		Muchous,	Juga		8900 REIST	ERSTOWN I	ROAD - P	IKESVIL	LE, MD 21208	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a aute	s Wara a consequence of):	dund	homo	whas	est,	Approximate Interval Between Onset and Death	
e be executed sicien and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):								
bur bur	ā	d								
2 2	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 W Unknown	23c. If yes, outcome of the control	2 ☐ Fetal death 3	B⊟Ectopic pregnancy S⊟ Other (specify)			23d. Dat Mor	e of delivery hth Day Year	
w requires that the de been signed by the s should be detached		Part II. Other significant conditions of	cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobact				. /	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown		
						7	24a. Was a autops perform	med?	Vere autopsy findings available prior to completion of cause of leath?	
Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Inpatier	nt 2□ER/Outpati	ient 3□ DOA Oth	26. Place of Deat			or (Specify)	
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation; T	1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Nursing Home 5 Residence 27. Manger of leath 1 Alatural 5 Pending (Month, Day Year) 28b. Time of Injury Work? 28d. Negrotian Nursing Home 5 Residence 28d. Describe how in 1 Natural 5 Pending (Month, Day Year) M 1 Yes 2 No								
tel or Atters safter de el Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Street)				treet and Numbe n, State)	t and Number or Rural Route Number, State)			
the Hospitei hin 24 hours a the Funerei npietely filled	edical	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best on the basis of and manner states	examination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the cred at the time, d	ause(s) and mai ate and place, a	nner as stated. and due to the cause(s)	
29b. Signature and title of certifier 29d. Date RES 000								9d. Date signed	te signed (Month, Day, Year) 8 5 Z	
15		30. Name and address of person who SEAN VAN ZIJL,		oath (Item 23a) (Typ	e, Print)	TIMORE, N	4D 21215	4 4		
Sta Registra		31. Date filed (Month, Day, Year) AUG 1 1 2004			porks					

			1 - For Stete Registrer		ryland / Depa	artment of F			Reg. No.	25216	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	aath Day Yea	3. Time of Death	
	/Medi		INCOM VIN 13: Provis					8	6 200		
7	Examir	ner	4a. Facility Name (If not institution, give street and number)				r Location of Death	1	4c. County of D		
			Johns Hopkins		. (In In a bringh In)	If Under 1 Year	If Under 24 Hrs.	T 2 D		ne City	
	Funeral Director		217-30-3955 1 ⋅ M 2 □ F 70 Yrs. Months Days Hours Min.					(Month, Da		Birthplace (State or Foreign Country) Maryland	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	dary sept	ō	Maryland Balt	imore			Dunđa l k			1 ☐ Yes 2X No	
	28e	Je C	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?	
	3a or	Ö	205 David-read David				2 1 222		United St		
	ms 2	Jera	305 Parkwood Road 11. Marital Status	12. Was Decedent 8	ver in U.S. 13.		dispanic Origin? (S) an, Mexican, Puerti	pecify Yes or No		merican Indian,	
9	after or Ite	by Funeral Director	1 Never Married 2 Married	Armed Forces?	lo			o Rican, etc.)		hite, etc.	
03	rat',	1 by	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White	
21215-0036	within 72 hours after death with the Maryland ene. than "naturat", or Items 23e or 28e-f show ha Mudigal Examinar must be multied at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de <i>completed)</i>	16a. Dece (Give	dent's Usual Occup	pation during most of world)	king	16b. Kind of Busine	ss/Industry	
21	Althin ne. han	idm	Elementary/Secondary (0-12) 12 Years	College (1-4or 5	+)						
	filed w Hygiel other then			0	Mac	chine Ope		- /Final Ministr	Steel Ind	dustry	
and	be fi	Be	17. Father's Name (First, Middle, Last)					ne <i>(r-irst, middi</i> e ni Zimme	, Maiden Sumame)		
ĭŽ	should be t and Mental I s marked o umatic ave	²	Russell Harri 19a. Informant's Name/Relationship (7		10h Maille	Add (04				7.011	
Maryland	d 2 sl th and 7 Is r			Daughte					er, City or Town, State , Maryland	2 1 222	
	1 and Health em 27		Sandra Harris / 20a. Method of Disposition	Daugiree	20b. Place of Dispo	sition (Name of		Date	20c. Location - City	or Town State	
nor	Pages nent of I int: If its		1X Burial 2 ☐ Cremation 3 ☐		cemetery, crei	natory or other place	·		Dorsey, 1		
Baltimore,			'4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License		Meadowria	Name and Addre	ss of Facility				
Ba	permit. Departr Importe any inju		12 Lake		I	Duda-Ruck	Funeral		Dundalk,		
			23a. Part Enter the disease, or comp	olications that caused	the death. Do not ent				Maryland rrest,	21222 Approximate	
	Physician		shock, or heart failure. List only of Immediate Cause (Final	-	inetary t	^				Interval Between Onset and Death	
X	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	-arrane					
	Examiner		Conventially list and distance	COP	D. exacer	-bahoin				2 weeks	
	п. ≔	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					Zweeks Zweeks		
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8760,	ate be executed hysician and the burial-transit	Ē	resulting in death) cast	Due to (or as a	consequence of):						
87	physics the k	dical	•	d							
9 ×	leath certific attending p	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy						
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00	s bee	ojet	CHF					24a. Was		4b. Were autopsy findings available	
æ	The law cate has page 2 :	Completed							prior to completion of cause of death? 2 \(\sum No \) 1 \(\sum Yes \) 2 \(\sum No \)		
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f V	Physician: this certific al director,	ToE	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatier	nt 2 ER/Outpatien	t 3 DOA Oth	er: 4 🗌 Nursing He	ome 5 Resid	dence 6 □Other (S _i	pecify)	
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe I	now injury occurred		
30	endil sath. or: A he fu	atic	2 ☐ Accident investigation				Yes 2 □ No	0			
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and manner stated. o et a control one) and manner stated. 29c. License number								29d. Date signed (Month, Day, Year)			
	May May							1 /	8/6/2004		
/			30. Name and address of person who o	completed cause of de	ath (Item 23a) (Type		- 1- 1-			,	
5		. 3	MARK YODER, M.D.				R., 4940 E.	ASTERN A	AVE., BALTO.	MD 21224	
	Sta		31. Date filed (Month Day, Year)	004 32. Registra							
	Registr	ar	HOULIZ	OUT TO	rs Signature	Span	4				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Oate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:30 PM Jesse Clifton Inabinet, Jr. 2004 August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Genesis Eldercare Hammonds Lane Baltimore Anne Arundel If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Oct. 5, 1 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F 228 03 5351 86 Director 1917 South Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 246 W. Edgevale Road 21225 U.S. or items 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White WW II 3 X Widowed 4 □ Divorced "naturai". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien Important: If item 27 is marked other th. any injury or other traumatic event, Impore. Inspector Stee1 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jesse Clifton Inabinet, Sr. Effie Rucker ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda C. Coleman 25 Hampton Road Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Bemoval from State Glen Haven Mem. Park 8/11/2004 Glen Burnie, Maryland A □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Scholice Oats 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ARTELIOSCI CARDIOVASCULAR **Physician** GLOTIC resulting in death) /Medical Due to (or as a consequence of) Y GANS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of). the attending physicien Completed by Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown FIBRILLA TION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 2 4NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 ☐ Could not be 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

within 24 hours a To the Funerel I the Hospitel

of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) AUG 1 1 2004

29b. Signature and title of certifier

MUNDIA 10 32. Registrar's Signature

MD

and manner stated.

X leedy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D21776

29d. Date signed (Month, Day, Year)

HANDURA ST. BACTIMORE EKZ

AUGUST 9, 2004

3001

			For State Ragistrar	State	of Maryland / Depa <i>Ce</i>	artment of He		-	ene	,
	Physici	an	Decedent's Name (First, Midd	le, Last)		_		2. Date of Death Month	Day, Y	ear 8 40 P M
	/Medic	al	George 4a. Facility Name (If not institution	n give street and n	Bernard	4b. City, Town, or L	nes	August	4c. County of	
	Examin	er	STAGNES	. 0	THCARE	BALTI			4c. County of	Death
	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	(00.5)	. Birthplace (State or Foreign
п	Director		213-30-1389	MM 2□F	71 Yrs.	Months Days	Hours Min.	(Month, Day, Y	33	Country) DC
	pur *		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
	lanyla aho	ŏ			-					1 ☑ Yes 2 ☐ No
	28a-1	Director	MD NA 10e. Street and Number		Baltim	10f. Zip Code		100	. Citizen of Wha	
	3e or	٥	4317 Fairfax	bood		2121	6		U.S.	
	ms 2	Funeral	11. Marital Status	12. Was Dec	cedent Ever in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		pecify Yes or No-	14. Race -	American Indian,
ဖွ	or Ite	교	1 Never Married 25 Mar	ried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 □ No		Specify:	o Hican, etc.)		White, etc.
903	ural',	d by	3 Widowed 4 Divorced	Year or l	Dates:				Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. Then "natural" or Items 23e or 28e-f ahow he Madical Exuminer must be indiffed at	Completed	15. Deceder (Specify only highe	nt's Education est grade completed) (Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion ring most of worl	king 16	b. Kind of Busir	ness/Industry
12	filed withir Hygiene. othar then ant, the M	m d	Sth grade		(1-4or 5+)	ustodian	1	R:	alto C	ity Schools
	Hygie othar ant.	0	17. Father's Name (First, Middle,	Last)	1			ne (First, Middle, Ma		icy benedib
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene it among 23e or 28e-f ahow itam 27 is markad othar then "natural", or Items 23e or 28e-f ahow other traumatic avant. The Madical Examinar must be indiffied at	To B	William Jone	S		L	aura S	priggs		
lary	2 should and Men is marka aumatic		19a. Informant's Name/Relations			ng Address (Street an				
	1 and 1 Health am 27 other tr		Theresa B. J	ones-Wii		Fairfax			1	
Baltimore,	permit. Pages 1 and Department of Health Important: If itam 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation	3 🗌 Removal from	1 State	matory or other place)				ty or Town, State
ij	permit. Pages Department of Important: If it any injury or c		' 4 ☐ Donation 5 ☐ Other (S					/13/04 (Owings	Mills, Md
Ba	permit. Departn Importa any inju		21. Strate of Fulleral Service	3X	eta Mão	2.Name and Address Arch F/H 300 Wabas	West h Ave,	Baltimo	ore, M	d 21215
г			23a. Part 1. Enter the disease, o shock, or heart solure. Lis	r complications that t only one cause on	caused the death. Do not ente	ter the mode of dying,	such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	-a. M	25A Pre	umoni	a			Unknown
	/Medical Examiner		resulting in death)	Due to	(or as a consequence of):					
ы		i.	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consequence of):		<u> </u>			
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	\						
o,	be executed ician and burial-transit	Exa	resulting in death) Last	C. Due to	o (or as a consequence of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d						
9	artifica ing ph e as tl	0 1	IF FEMALE:					A17. 1-55-1		
Вох	eath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 Live		Ectopic pregnancy			23d. Date of Month	
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<u>a</u>	that the de ed by the detached		Part II. Other significant conditi	ons contributing to	death but not resulting in the u	nderlying cause given	in Part I.	23e. Did toba	cco use contribu	ute to the cause of death?
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00	w requir s been si should	Completed						24a. Was an	24b. We	re autopsy findings available or to completion of cause of
	The lay	шо						autopsy performe 1 Yes 2	id?// dea	or to completion of cause of hth? I Yes 2 □ No
Vital	ician: Th certificate rector, pag	Be C	25. Was case referred to medica	al		2	26. Place of Dear	th (Check only one)	2140	1163 2 110
of V	hysic his ce I direc	70	examiner? 1 Tes 2 No	Hospital:	Inpatient 2 ER/Outpatier	nt 3 DOA Other:	4 🗆 Nursing Ho	ome 5 Residence	ce 6 Other	(Specify)
n o	nding Physician: th. : After this certifica s funeral director, p	on:	27. Manner of Death 1 Natural 5 □ Pendi	''9	of Injury of Injury of Injury 28b. Time o Injury	Work?		28d. Describe how	injury occurred	
Sio	Vttandii death. ctor: A y the fu	icat	3 Suicide 6 □ Could	not be	an of lainny. At home form at		s 2∐No	20f Location (Stro	ot and Alumbar.	or Burnt Banks Museline
Division	l or A after Dirac	Certification:	4 ☐ Homicide determ	nined 286. Plac build	ee of Injury - At home, farm, str ding, etc. <i>(Specify)</i>	еет, таскогу, опісе		City or Town,	State)	or Rural Route Number,
	spite lours naral		29a. Certifier 1 Certifyi	ng Physician: To th	ne best of my knowledge, deat	h occurred at the time	, date and place,	and due to the cau	se(s) and mann	er as stated.
	To the Hospitel or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	one) 2 Medica	Examiner: On the and ma	basis of examination and/or in nner stated.	vestigation, in my opir	nion, death occur	rred at the time, date	and place, and	d due to the cause(s)
	To th Within	×	29b. Signature and title of certific	er		29c. License r	number	290	. Date signed (/	Month, Day, Year)
,	(· CASA	mp		161PF	,95	A.	regust	-7th 2004
4)			30. Name and address of person	who completed cau	use of death (Item 23a) (Type.	Print) BABA	TUND	E OL.	UMID	E MD
9	- CI-		31. Date filed (Month Day Year	HEAL	Registrar's Signature	BALTI	MOR	E mo		J -
	Sta Registi	rar	30. Name and address of person TAGNES 31. Date filed (Month, Day, Year AUG 1 1 20	04 Ben	Jones &	parket				

Amanda E Johnson

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			For Stata Registrar		State of Ma	arylan		epartment of F Certificate of			_		
	*		Decedent's Name	e (First, Middle, La	st)					2. Date of De		2004	3. Time of Death
	Physici /Medic		Amanda	Elle	n John	son				Augus	Da † S	y Year 2004	11:50 PM
	Examin		4a. Fecility Name (If	f not institution, giv	e street and number)	2 1 1	n ' -	4b. City, Town, o	r Location of Deat	h '	40	c. County of Death	1
-	Funeral		5. Social Security N	umber 6 S	AV 7 AG	e (In yrs.	ast birthe	day) If Under 1 Year	If Under 24 Hrs		th	9. Birth	or Cd
	Director		290-22-32	281	_M 2₹ /		76 Yr	s. Months Days	Hours Min.	NOV • 1	3,70	1927 Miss	intry) SOuri
	and		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town o	or Location					10d. Inside City Limits
	Maryl Ired 2	tor	Maryland	Harford		Be.	l Ai	r					1 ☐ Yes 2 No
	or 286	Direc	10e. Street and Nun					10f. Zip Code			10g. C	itizen of What Cor	untry?
	within 72 hours after death with the Maryland ene. Then "naturel", or items 23e or 28e-f show he M. ofcal Examiner must be notified at	Funeral Directo	1651 Shuc	ks Road	12. Was Decedent	Ever in II	9	21015	Jispania Origina 19	pocify Vos or No		USA 14. Race - Amer	ican Indian
G	ufter de ritem uitner	Fune	11. Marital Status 1 ☐ Never Marri	ed 2 Married	Armed Forces? 1 ☐ Yes 2 1	10 10	3.	13. Was Decedent of H If Yes, specify Cub		to Rican, etc.)		Black, White	
003	urel', c	d by	3 X Widowed		If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:				nite
21215-0036	n 72 h	Completed		15. Decedent's Ed	ade completed)		(ecedent's Usual Occup Give kind of work done ife. DO NOT use retired	during most of wo	rking	16b. F	Kind of Business/l	ndustry
212	d with giene.	omp	Elementary/Second	ndary (0-12)	College (1-4or 5	i+)	Ass	embly Line	Worker		Car	n Manufac	cturing
nd	be file ta! Hy d othe event,	Be	17. Father's Name (_					me (First, Middle,	, Maidei		
yla	d Men marke maric	J.	Thomas 19a. Informant's Na	u/k	Barnes		10h A	Mailing Address (Street	Sarah	Jane	or City	Messer	in Coda)
Maryland	nd 2 sh Ith and 27 is r			, ,	,, ,	hter		Graceford					
ore,	es 1 ar of Hea litem		20a. Method of Disp		Domewal from State	20b. P	lace of E emetery,	isposition (Name of crematory or other place	се)	Date	20c. L	_ocation - City or T	Town, State
Baltimore,	Page ment tent: It		4 ☐Donation	5 Offier (Spesi		Dul	aney	Valley Mer					
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The proportent: If item 27 is marked other then "naturel; or items 23e or 28e-f show eny injury or other treumatic event, the Macrical Examination and be notified at once.		21. Signature of E	Service Live	nsee	_		22. Name and Addres				177	
			23a Part I. Enter th	he disease, or com	plications that caused	the deat	h. Do no	t enter the mode of dyir				I TRALYIC	Approximate
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	/Medical Examiner		resulting in death)		Due to (or as			:	-				DINGS
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, 0,	be executed ician and burial-transit	_	resulting in death) l	Last	Due to (or as	a conseq	uence of	!					
68760	9 2 9	dica		•	d								
Вох 6	ath certifi attending for use as	n/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome							23d. Date of deli	very
	ath	Physician/Medica	in the past 12 1 Tyes 2	months?	1□Live birth 4□Pregnant at 9□Unknown			3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	/			Month	Day Year
P.0	that the de ned by the s detached (9 Unknown			ut not res	ulting in t	he underlying cause giv	en in Part I	23e Did t	ohacco	use contribute to	the cause of death?
ds,	w requires t been signe should be o	d by			Ancurysm		annig mi t	no undonying oddao gri		1)(1)			bably 4 Unknown
Vital Records,	aw req us beer 2 shou	Completed			,					24a. Was			opsy findings available
- Re	The ta ate ha page 2	omi								autor perfo	osy rmed? 2(X.N	death?	ompletion of cause of
/ita	ii jij	Be	25. Was case refer examiner?		Hospital:			Cost		ath (Check only o	one)		
of	this al dii	To To	1 ☐ Yes 2 <a>Z 27. Magner of Deat		28a. Date of Inju		ER/Outp		a Sursing i	lome 5 Resident		6 Other (Spec	ify)
ion	Attending it death. ector: After by the fune	atlor	1 Natural 2 Accident	5 Pending investigatio	(Month, Da	ý Year)	Inji	iry Wo	rk? Yes 2□No		Í	,	
Division	or Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ury - At ho	ome, farm	n, street, factory, office	_	28f. Location (: City or Tox	Street a	and Number or Rule)	ral Route Number,
	pitel o		29a. Certifier	Certifying Pl	aveiging. To the best	of mu kna	- Indiana	death occurred at the ti	me date and place	and due to the		-) and	
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	(Check only one)	2 Medical Exa	miner: On the basis of and manner sta	f examina	tion and/	or investigation, in my o	opinion, death occi	urred at the time.	date an	nd place, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and	title of certifier	4 - 3			29c. Licens				ate signed (Month	
				1111	ND			103)	1672		ALLY	ust 6	2004
10)		30. Name and addr	ress of person who	completed cause of d	Nov/	h 23a) (T	ype, Print) Avenue	B1/ A1.	Mary	, /R	nU 21	1014
• -	Sta		31. Date filed (Mon		Sa. Registr			10011					
P. 1	Regist	ar	AUG I	L 2004	CIA PROVI	N	19	could					

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death		Reg. No P	25220
	Physicia	n	1. Decedent's Name (First, Middle, Last) Mary P. Kuhn	2. Date of De Month	Day Yea	3. Time of Death 4:45am
No.	/Medic	al .	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Lo.	Augus cation of Death		
ĺ	Examine	er	Westminister Nursing Home Westmin		Carro	oll
Ŋ	Funeral Director			8. Date of Bird Sept.	8 , 1926 Ma	sirthplace (State or Foreign Country) aryland
	hend	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-f sh	ţō	MD Baltimore Baltimore			1 ☐ Yes 2 🙀 No
	th with the 23e or 28	Funeral Director	10e. Street and Number 7707 East Baltimore Street 21224		10g. Citizen of What o	Country?
21215-0020	Jrs e	۾	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Was Decedent Ever in U, S. Armed Forces? 1 □ Ves 2 □ No If Yes, specify Cuban, Mexican, Puerto I I □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	ecify Yes or No Rican, etc.)	14. Race - Ar Black, Wi Specify: Wh	
15-0	natu	jetec	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of workii life. DO NOT use retired)	ing	16b. Kind of Busines	ss/Industry
212	filed withir Hygiene. other than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker		own home	е
	e filed al Hygi other vent, ti	S S	17. Father's Name (First, Middle, Last) 18. Mother's Name		Maiden Surname)	
ylai	should be find Mental himarked of	To Be	Max Petryszak MAry	•		
, Maryland	1 and 2 sho Haalth and em 27 is m		19a. Informant's Name/Relationship (Type, Print) Joseph Kuhn / son 19b. Mailing Address (Street and Number or Rura 820 Flintlock Drive	e Bela	ir MD	
Baltimore,	permit. Pages 1 Department of His Important: If Iten any injury or oth		20a. Method of Disposition 1 \(\text{Surial} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify)} \) 20b. Place of Disposition (Name of cemetary, crematory or other place)} \) OakLawnCemetery	/11/04	20c. Location · City of Baltimo:	· ·
Balt	permit. Departi		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Co. 300 Mace Ave.	nnelly Baltim	FuneralH nore MD 2	omeofEssex
	2		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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68760,	tificeta be g physicie es the bu	Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
Вох	eath cer attendin I for use		d			
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	that the hold by detail	by P		10	Yes 2.0XNo 3□	Probably 4 Unknown
Records,	s been signs should by	Completed b			an autopsy 24t med?	b. Were autopsy findings available prior to completion of cause of death?
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of	Physician: r this certific ral director,	2			dence 6 Other (Sp now injury occurred	pecify)
On	Attending in death. Boton: Aftar by the fune	틽	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c.		ion injury coodinoc	
Division	i or Atter after dea Director d in by the	Certification:	a Classic Could not be	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificata has complataly filled in by the funeral director, paga 2	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the control of my knowledge, death occurred at the control of my knowledge, death occurred at the control of my knowledge, death occurred at the control of my knowledge, death occurred at the control of			
_	To th To th comp	Z E	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
	1		1 26MM D00581	37	8111/	04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilbu Was 295 Stower Ave St 307 We	stmm	ste M.	21157
	Stat Registra		31. Date filed (Minut Gay Year) 2004 32. Registrar's Signature & Apollor			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 08.01. Year **Physician** 12:00 PM VELYN /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE NORTHWEST HOSPITAL RANDAUSTOWN 8. Date of Birth (Month, Day, Year 12-15-3 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f shov traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Funeral Director HIMOre 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 21216 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 14. Race American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify: Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "na any njury or other traumatic auch." Elementary/Secondary (0-12) College (1-4or \$ ISABlea 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Watter King d Batto. 19a. Informant's Name/Rel ship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister 0-Ann 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 8-13-04 MARRIOTISVILE, NO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa are of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATE PIKE BALTO. MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease of ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ons contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, leu Cule page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. M 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by determined 4 Homicide within 24 hours a To the Funeral C completely filled is tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce rtifie 08-09-04

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

properted cause of death (Item 23a) (Type, Print).

LOWDERIM

32. Registrar's Signature

-NWHC

		·	1 - For State Registrar		Marylan		artment rtificate			d Mental Hy	gien	1001	25222
	Physici /Medic		1. Decedent's Name (First, Middle Albert	W.		Krie	ger			2. Date of De Month	eath C	2004 Year	3. Time of Death 2113 p M
	Examir		4a. Facility Name (If not institution lohns Hopkins Buy	view Medica	2 Cem	er	4b. City, To	zHi	move			c. County of Dea	
	Funeral Director		5. Social Security Number 217-20-3620 Usual Residence of Decedent	6. Sex 7.	Age (In yrs.	77 Yrs.	If Under 1 Months		f Under 24 F Hours M	lrs. 8. Date of Bi in. (Month, D. Janua)			thplace (State or Foreign ountry) Maryland
	e Maryland	ctor	10a. State 10b. County MD Balt:	imore		y, Town or Lo indalk	ocation						10d. Inside City Limits 1 ☐ Yes 2X No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural, or Items 23a or 28a-f show other traumatic event, If a Medical Examination and the rediffied at	neral Director	10e. Street and Number 8201 Cornwall 1 11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.		222	anic Origin?	(Specify Yes or Note to Rican, etc.)		itizen of What Co USA 14. Race - Ame	erican Indian,
215-0036	hours after tural', or Ite	ed by Funeral	1 Never Married 2 Marria 3 Widowed 4 Divorced	If Vac Give			if Yes, specifi 1 ☐ Yes 2 dent's Usual	No S	Specify:	erto Hican, etc.)			nite
21215-	d within 72 giene. rr than "nai	Completed	(Specify only higher Elementary/Secondary (0-12)		or 5+)	(Give	kind of work DO NOT use	done duri retired)	on ing most of t	working		Kind of Business	rewing Co.
Maryland 2	ould be filed Mental Hyg arked otheratic event,	To Be C	17. Father's Name (First, Middle, Henry	Last) Krie	eger			18	3. Mother's Nary	Name (First, Middle	, Maide	n Sumame) Priber	
	and 2 sho lealth and im 27 is mu		19a. Informant's Name/Relations Barbara Rossi	hip (Type, Print) (niece)	205 8	8201	Cornw	all E		Rural Route Numb	MD.	21222	
Baltimore	t. Page tment c rtant: If rjury or		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 4 □ Donation 5 □ Other (S 21. Singleture of Funeral Service	pecify)	ate C		natory or oth Servic	erplace) e Col		Date 3/09/2004	To	ocation - City or	D.
Ba	permi Depar Impo any ir		172	C. C.	and	7	922 Wi	se A	ve. Du	ida-Ruck indalk, M	D. 2		Dundalk, Inc
	Physicían /Medical Examiner		23a. Part1. Enter the disease, or snock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. PN	sed the death h line.	onia	er the mode	of dying, s	such as card	liac or respiratory a	irrest,		Approximate Interval Between Onset and Death
8760,	ate be executed nysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequal as a consequal								
P.O. Box 68	that the death certifical led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of d	Ideath 3	Ectopic prec Other (spec					23d. Date of del Month	ivery Day Year
	w requires that been signed t should be delt		Part II. Other significant condition Paypo Hension	and the second s		ulting in the u	nderlying cau	se given i	in Part I.				the cause of death?
Division of Vital Records,	The law I	Completed by								24a. Was auto perfi 1 Yes		death?	itopsy findings available completion of cause of 2 No
of Vita	hysicier his certif Il director	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 1 1 1	atient 2	ER/Outpatier		Other:	4 🗌 Nursin	Death (Check only) g Home 5 Res		6 □Other (Spe	cify)
sion o	To the Hospital or Attending Physicien: whihin 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	27. Manner of Death 1 X Natural 5 Pendir 2 Accident investignation 5 Could	gation		28b. Time of Injury	М	: Injury at Work? 1 ☐ Yes	3 2 □ No	28d. Describe	how inj	ury occurred	
Divi	oital or At urs after o sral Direc	Certif	4 Homicide determ	ined 286. Place of building	, etc. (Specify	/)				City or To	wn, Sta	te)	ural Route Number,
	the Hospin 24 ho	ledical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basi and manne	is of examina	wledge, deatl tion and/or in	vestigation, in	n my opini	ion, death o	ace, and due to the courred at the time,	date ar	s) and manner as nd place, and due	stated. to the cause(s)
) (To To Corr	M	29b. Signature and title of certifie	Asuni	, Mb.			License ni 2664		+358		ate signed (Mont) $G/200$	
19			30. Name and address of person Bolanie Asuni		of death (Item			lhw/	ne H	b 212a		4.5	
	Sta Registi		31. Date filed (Month, Day, Year)		istray's Signa	ture		boar			.9		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 08 3:30AM 2004 de /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 306 N. CULVER STREET N/A BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF 70 Yrs. MD 29-32-1da03 Director 26/1931 Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic event, the Medical Examiner must be notified at MD BALTIMORE 1 XYes 2 □ No Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 0 21229 304 N. CULVER STREET U.S.A. natural', or items 23a death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. illed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL TECHNICIAN HEALTHCARE 12th grade 2 years permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERMAN WILLIAMS, SR. MARY BARNES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NATHANIEL A. LEWIS 300 N. CULVER STREET BALTIMORE, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BARRISON FOREST D8.12.04 UNINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICES 5151 BALTIMORENATIONAL PIKE BALTO, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causes need hine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Lun Cancer Examiner 5 sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and does detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MICH 2 🗆 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed2 certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: filled in by the funeral director. 25. Was cas refer ed to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death

1 XNatural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No s after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical tely within 2 To the complet 29c. License number 29b. Signature and title prentifier 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 94UG 1 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Timer of Beath 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** J. Frank Memmo August 6 2004 2:25 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Catonsville Catonsville Baltimore tf Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1**√**M 2□F Yrs. 58 Director 219-42-9542 1945 Maryland Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ₩ No Director Maryland Baltimore Relay 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 United States 5125 South Rolling Road , or itams 23a fited within 72 hours after deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. JYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Own Business 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) p-mit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic svent one. Be Mary Vecchione Joseph Memmo ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Byerly - Wife 5125 South Rolling Road Relay, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 8/9/04 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gary L. Kaufman Funeral Home At MMP., 21. Signature of Furreral Service Licensee 10 7250 Washington Blvd. Elkridge, Maryland 21075 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final Type 2 Diabetes Physician distant disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atherosclerotic Peripheral Vascular Disease distant Sequentially list conditions, it any, leading to influe diatacause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed distant Renal Failure, Acute resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Renal Failure, Chronic distant Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Year Day 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete hes autopsy med? 2€ No 1 ☐ Yes 2 ☐ No Division of Vital Hospitel or Attending Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2/ No 3 DOA After this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending To the Hospitel or Attending within 24 hours after death.
To the Funsrel Director: After completely filled in by the fun tx Natural 1 🗌 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Intury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D25001 -10-04 30. Name and a doess of person who completed cause of death (Item 23a) (Type, Print) Jay H. Lippman, M.D. 200 Rosewood Lane Owings Mills, Maryland 21117 37. Registrar's Signature 31. Date fited (Month, Day, Year) AUG1 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year FRANK E 1125 A MOLNAR ALLGUST C 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 30 HOUS HOPKING BAYVIEW If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 3740 85 Yrs Director Pennsylvania Februcius 1 1919 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or Itams 23a or 28a-f shov avent. The Medical Examinar must be notified at Baltimore MARYland Dundalk 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 States 1403 Vesper United Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 Yes 22 No Specify. à Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Driver Eltotric 10 Truck GAS permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: if Item 27 is marked othe any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Molnar Frank MATY Bendia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) N Molnar Yesper Ave Dundalk, MD. Gemma SPOUSE 1403 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, cromatory or other place)
Sacred Heart of Jess 1 ■ Burial 2 □ Cremation 3 □ Removal from State 12 2004 Jesus Dundalk *4 ☐ Donation 5 ☐ Other (Specify) Ava. 22. Name and Address of Facility 21. Signature of Foreral Service Licenses 22. Name and Tract ...
Connelly Tract ...
Sollers It. Dundale, P.A. Home 64 K Dundalk, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNELLOIDINIA Z, MONTHS /Medical Due to (or as a consequence of) Examiner CHRONIL OBSTRUCTIVE PULLONARY DISERSE /EAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): JEAR J physicien and s the burial-trans LUNG CANCER Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by RESECTION LEFT should t LONGR LOTS I Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed RESTECTION RIGHT KPPER 792 24a. Was an LO 3515 24b. Were autopsy findings available prior to completion of cause of death? Sec autopsy performed? ASBESTOSIS 1 ☐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury investigation М 1 □ Yes 2 □ No 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of sertifier 29d. Date signed (Month, Day, Year) D04383 ANGUST 9 200L 4 CIRCLE 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) 5505 1+05 K 1 IUS BAYUIEW 13 GREENOUGH IL HO TIMER I 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gloria Ella Madison 6, 2004 August 3:30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien Nursing Home Columbia Howard If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕅 E Director 22, 1929 223-34-8373 74 Virginia Nov. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits 1 Yes 2X No Director Maryland | Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 7907 Chalice Road 21144 United States Completed by Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. 11th 0wner Video Store permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy Importent: If item 27 is marked other eny injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John В. ဂ Long Lillian L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Harris Farm Lane Clarksville, Maryland 21029 Dan R. Madison/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 8/10/2004 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Unamas manta ox M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Sequentially list conditions, I ary, Jacung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ending physician and use as the burial-transit c Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🏋 No ģ Month Day Year 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been signal 1 ☐ Yes 2 ☐ No 3 Probably 4 TUnknown Completed 24a. Was an certificate has autopsy performed? page 1□ Yes 2√□ No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ٥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of After ti Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural Injury 5 Pending within 24 hours after death. To the Funeral Director: A М 1 Tyes 2 No 2 ☐ Accident investigation the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical mpletely (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) land 30641 August 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Baltimore, Maryland 21213 Erdman Avenue 3. Registrar's Signature State AUG 1 1 2004 Registrar

		•	1 = For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>			ene g. No 2 0 0 4	25227
T _e	Physicia		Decedent's Name (First, Middle, Last, DANTEL		1	/USER		2. Date of Death Month AUGUST	8, 2004 Year	3. Time of Death 10:58 PM
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)			Location of Death		4c. County of Dear	
9A.			10308 CASCADE RUI	N COURT			GS MILLS			TIMORE
	Funeral Director		5. Social Security Number 133–18–6875 6. Sec. 15	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	B. Date of Birth	9. Bin	thplace (State or Foreign ountry) NY
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	MD BA	ALTIMORE	OWI	NGS MILLS				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	th with	al D	10308 CASCADE RUI	N COURT			21117			USA
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland tall Hygiene. dother than "natural", or Items 23e or 28e-f show of other than "natural", or Items 25e or 28e-f show event, the Medical Examinat must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XX Yes 2 □ No If Yes, Give Year or Dates:		1□Yes 2♥No	Specify:		Specify:	WHITE
8	2 hour		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	ition	1	6b. Kind of Business	/Industry
215	within 72 ene. than "n	ple	(Specify only highest grad	e completed) College (1-4or 5+)	life.	kind of work done a DO NOT use retired,)			
2	e filed within al Hygiene. I other than '	Completed	12		CIV	IL ENGINE			TATE OF MA	ARYLAND
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last) LOUIS		MUSI	P	18. Mother's Name		laiden Sumame)	BINDER
ız	E DEE	၉	19a. Informant's Name/Relationship (T)	rpe, Print)					City or Town, State, J	
	tith a		LUCILLE MUSER / N	NIFE	10308	CASCADE	RUN COUR	T - OWIN	GS MILLS,	MD 21117
ore,	ges 1 ar t of Hea If item or othe		20a. Method of Disposition 1	0.0	ace of Dispo	sition (Name of natory or other place		Date 2	Oc. Location - City or	Town, State
Ë	Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Specify)		I ISR	AEL CEMETI	ERY 8/10	/2004	BALTIMORE	E, MD
Baltimore,	permit. Pag Department Important: f any injury o		21. Signature of Funeral Service Licens	Punal		2. Name and Addres			ON & BROS	
	*		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death ne cause on each line.	. Do not en	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Cardio	20	myth	~e			Onset and Death
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	8. A.	er	Sequentially list conditions. if any, leading to immediate	Due to (or as a onsequ	ience of):	Jenn	Farle			
	outed d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Genel	-	Dre	rosche	u;		
o,	e exection and initial-tr	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					
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		/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv				22d Date of do	livon
Вох	death certif e attending id for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
Ö.	the y th	hysi	9 Unknown	9□ Unknown						
S, P	as the	by P	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause give	en in Part I.		acco use contribute to	
ord	w require been si should I	ted						1 ∐ Ye	s 2∏No 3□Pr	obably 4 □Unknown
Records,	e taw has b	Completed						24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
alF	n: The ficate ha		ac 111					1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2 ☐ 8	EB/Outpaties	nt 3 DOA Othe	26. Place of Deatl	V	nce 6 Other (Spe	oife)
of		-	27. Manner of Death		28b. Time o			28d. Describe how		City)
Sior	Attending F r death. ector: After by the funera	atlo	1 Natural 5 Pending 2 Accident investigation	(World), Day 1 day	Hijury		Yes 2 □ No			
Division	F 9 E C	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ro State)	ural Route Number,
_	Hospita 14 hours Funerel tely filled	Medical Co	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exemi	sicien: To the best of my knowner: On the basis of examinat and manner stated.	wiedge, deat ion and/or/in	n occurred at the tim vestigation, in my or	ne, date and place, pinion, death occur	and due to the cared at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and the of certifier			29c. License	number	29	d. Date signed (Mont	h, Day, Year)
	C>F0		Day 51	DU IN	1	W D	08029 MD		AUGUST 9	, 2004
11			30. Name and address of person who co	ompleted cause of death (Item	23а) (Туре,	Print)		LITHOC III		
10			J. STEPHEN MARGO				#135 - C	WINGS MI	LLS, MD 2	111/
, e.	Sta Registi		31. Date filed (Month, Day, Year) ANG 1 1 2004	32. Registrar's Signa	Tre A	saks				

				1 = For State Registrar	State of	Maryland	•	rtment of H	Health and M Death	/lental Hy	giene	11.	25220
				1. Decedent's Name (First, Middle, Las	t)	-				2. Date of De	eath	No. Sec.	3. Time of Death
		Physici /Medio		Jessie Lenora	Morkovs	sky				August	9, 2004	Year	2:25 A M
		Examin		4a. Facility Name (If not institution, give	street and numb	oer)		4b. City, Town, o	r Location of Death		4c. County of	of Death	
				Gilchrist Center				Towson			Balt		
		Funeral		5. Social Security Number 6. Se	ox 7. ⊐M 21. 0 F	Age (In yrs. la.	V	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year)		lace (State or Foreign try)
		Director		216-36-6637 Usual Residence of Decedent		6	4			May 2	6, 1940	West	<u>Virginia</u>
		yland now		10a. State 10b. County		10c. City,	Town or Lo	cation				11	Od. Inside City Limits
		Mar Mar	tor	Maryland Harford		Bel	Air						1 □Yes 2 📉lo
		th the	Sire	10e. Street and Number				10f. Zip Code	*		10g. Citizen of W	hat Coun	try?
		ath w	ral	3132 Nova Scotia	Road			21015			USA		
		er de	Funeral Director	11. Marital Status	12. Was Deced	es?	. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race Black	 America White, e 	an Indian, etc.
•	36	rs aft	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1	☐ Yes 21/2 No	Specify:		Specify:	Whi	+0
Z	21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow he Medical Exami he must be politied at	ted	15. Decedent's Ed	ucation		16a. Deced	ent's Usual Occup	ation		16b. Kind of Bus		
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10		ygien ygien t.	Completed	9			Hon	emaker			Own Hon		
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N.	ž	hould d Mer narke	ို	Warren (nmn) 19a. Informant's Name/Relationship (T		COSS	10h Mailie	a Addraga /Ctmat	Neoma	(nm	•	mber	
	Z	th an the anterior and the anterior a		Mary E. Wheeler -		\r			and Number or Rui rood Lane		5957		
a	ē,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23e or 28e-f ehow other treumatic event. The Medical Example annual termolities and present annual termolities are consistent to the property.		20a. Method of Disposition	Daugitte	20b. Pla	ce of Dispos	sition (Name of latory or other place		Date	20c. Location - C	-	
	Baltimore,	permit. Pages Department of I Importent: If ite any injury or of		1 Burial 2 Cremation 3 4 Donation 5 XOther (Specify	Removal from St. Fintombm	are i	-		· I	2/04	NI - wiles	270	and and
4	alti	permit. Departm Importe any inju		21. Sign ture of Funeral Service Licens	600	1	22	Name and Addre	ss of Facility Mc		Aberdeer Funeral H		
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7	٣.	res that thisigned by	by Ph	Part II. Other significant conditions co	ntributing to dea	th but not result	ing in the un	derlying cause giv	en in Part I.	23e. Did t	obacco use contrib	ute to the	e cause of death?
N	rds	w requires been sign should be								1 🗆	Yes 2 No 3	□ Proba	ably 4 □Unknown
\$	000	law requires that the as been signed by th 2 should be detache	plet							24a. Was		ere autop	sy findings available
9	of Vital Records	The tav ate has page 2	Completed							autor perfo	rmed? de	ath?	npletion of cause of 2 No
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Σ		ding h. After funer	tlon	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of (Month,	Day Year)	8b. Time of Injury	28c. Injun Worl	y at k? Yes 2 □ No	28d. Describe	how injury occurre	1	
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ESS		To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the be iner: On the basi and manne	s of examinatio	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and man date and place, ar	ner as sta d due to	ited. the cause(s)
7		To the within 2 To the complet	Me	29b. Signature and title of certifier	1 1			29c. License			29d. Date signed		
)			M. Anthon	, Ilile	z, m	O	Da	5205		August	9,0	200x
	0			30. Name and address of person who d	ompleted cause	death (Item 2	(Type, F	rint) alles ST	. Pol	to md	August 2121	باره	
		Sta		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatu	re		16				
		Registr	ar	AUG 1 1 2004	Lieur	13	100	reks9	•				

			1 - For State Registrar	State of	Marylar	•			lealth and Death	Mental Hy	/giene	200		25229	
			Decedent's Name (First, Middle, Last)					-		2. Date of D	eath		d .	3. Time of Death	
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	/Medic		Benjamin 4a. Facility Name (If not institution, give st.	most and numb	osl .				r Location of Dea			. County of		0115	_
	Examin		university specialty				-	. 4	rure						
						last birthday)			If Under 24 Hrs	R Date of B	irth		0 Rittho	lana (Stata or Forniga	_
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	Director		247-48-2461 Usual Residence of Decedent		71					02	18	32	S	·C	_
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	or 2	Director	10e. Street and Number				101. 21	Code			log. Ci			iuy:	
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5-	within 72 hours after ane. than "naturel", or Ite to Medicul Examine	ete	15. Decedent's Educa (Specify only highest grade	ation co <i>mpleted)</i>		(Give	edent's Usu kind of wo	rk done	during most of we	orking	16b. h	(ind of Bu	siness/In	dustry	
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<i>a b</i>	e filed al Hygi I other vent, I	Be (17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middi	e, Maidei	Sumame	θ)		
\overline{a}	ould be Mental arked o	2	EZ Nelson						Roset	ta McFa	adde	n			
Renjamin — Maryland 21215-0036	2 sho and h Is ma euma		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Maili	ing Addres	s (Street	and Number or F	ural Route Num	ber, City	or Town, S	State, Zip	Code)	
W Z	nit Pages 1 and 2 should be filed within 72 hours after death with the Marylan ariment of Health and Mental Hygiene. orient: if item 27 is marked other than "naturel", or Items 23a or 28e-f show in ury or other treumatic event, the Medical Examinar must be notified at in ury or other treumatic event, the Medical Examinar must be notified at 8.		James Nelson Sr.	-Brot	her	B825	Pal'	Ma	11 Roa	d, Bali	time	re.	Md	21215	
, e	thealth tem 27 other tr		20a. Method of Disposition		20b. I	B825 Place of Disponentery, cre	osition (Na	me of	(a)	Date	20c. L	ocation -	City or To	wn, State	_
Ilgon altimore	ages int of t; If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from Sta						0 /0 /	D - 3	Z	2.5	N4 -3	
- THE	ran n	V.	21. Signature of Funeral Service Ligense		ME.				ery 8/1	0/04	Bal	time	ore,	Ma	-
Bal	permit Page Department of Important: If any in ury or once.				1.	M	arch	FZE	ss of Facility West						
)	40 = 4 G		1 Joshus 13	7	+-	4:	300 1	Vaba	sh Ave	, Balt	imor	e, I	Md -	21215 Approximate	_
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that cau	ised the dea th line.	th. Do not en	iter the mo	ae ot ayır	ng, such as cardi	ic or respiratory	arrest,			Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	Lun	ng a	bsca	20						*	2 months	
_	/Medical		resulting in death)		as a conse										
	Examiner			#15	berg	1110	na							2 month	-2
		er	Sequentially list conditions, any leading to introduce cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse	quence of									
	s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events												
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760,	tte be ex tysician ne burial	call													
687	<u>~</u> ~ <u>~</u> •		d.												
×	ding Se a	by Physiclan/Med	IF FEMALE:	c. If yes, outco	me of prean	ancv						23d. Date	a of delive	arv.	
Bo	atten atten for u	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt 4 ☐ Pregnar	h 2 🗍 Feta	aldeath 3	□Ectopic p		у			Mor		Day Year	
<u>.</u>	e de the a	Sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow		ueam 5	∟ Otner (s	pecity) _							
9.	at th d by etacl	F.							on in Dark I	22a Die	1 tobacco	use contr	ibuta ta ti	ne cause of death?	-
Division of Vital Records, P.O. Box	gner	þ	Part II. Other significant conditions cont	nouting to dea	in but not re	suiting in the t	undenying	cause giv	ren in Faiti.						
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Ş	s be	Completed								24a. Wa	s an	24b. V	Vere auto	psy findings available mpletion of cause of	
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⋚	sicia cert rect	Be c	avaminar?	ospital: 1 🗹 Inc	national OF] ER/Outpatie	200	Oth Oth	200	Home 5□Re		6 🗆 🗆	ne /Chaoit		_
oţ	Phy this ral d	2	27. Manner of Death			28b. Time		- Tell 100		28d. Describe				y)	-
n	fing After fune	5	1, ■Natural 5 □ Pending	28a. Date of (Month,	Day Year)	Injury	м	28c. Injur Wor	rk? Yes 2.∐No		ŕ	•			
Sic	tend Jeath tor: the	Certification;	2 Accident investigation 3 Suicide 6 Could not be	on- Disease	flaire. At h				100 2010	29f Location	(Stroot a	nd Numb	or or Purs	al Route Number,	_
₹	or At iter of irec n by	ı.	4 ☐ Homicide determined	building	, etc. (Spec	nome, farm, s ify)	treet, racto	ту, описе		City or T	own, Star	e)	BI OI HUIC	ir Houle Namber,	
	ital curs a			1/4						W.					
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin												
	the h	edi	one)	and manne											
	To to to to to to to to to to to to to to	Σ	29b. Signature and title of certifier	1 A A			29	c. Licens	se number	/:	29d. D	ite signed	(Month,	Dey, Year)	
			> CfMohta	MID				0 9	5497	4	thu	gusi	,4	2004	
ñ			30. Name and address of person who cor	npleted cause	of death (Ite	m 23a) (Type	, Print)	.11	0/	1		11	211	Smara	
9			CHARU MEI	ITA,	MD	,601	,700	けん	chai	ses s	800	+1/7	MD.	12004 12004 12004	
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	Dhysisi		1. Decedent's Name (First, Middle, Last,		-			2. Date of Dea		3. Time of Death
	Physici /Medi		Lytle T.	Osborne				August	6, 2004	12:52PM M
	Examir	ner	4a. Facility Name (If not institution, give Southern Maryland	Hospital (Clinto				ce George's
l	Funeral Director		5. Social Security Number 6. Set 245–10–6706	7. Age	'In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 6/26/19	7 Year)	9. Birthplace (State or Foreign Country) North Carolina
	nyland how		10a. State 10b. County		0c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	cto	Maryland Prince Ge	orge's	Oxon Hil					1 □ Yes 2 ☑ No
	h with th	al Dir	10e. Street and Number 6700 Livingston R	oad		10f. Zip Code	20745		10g. Citizen of V	Vhat Country? JSA
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heath and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other freumatic event, the Medical Examer must be routified at	by Funeral Director	11. Marital Status 1 □ Never Married 27 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1√1¥es 2 □ No If¥es, Give Year or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)		e - American Indian, k, White, etc. : White
21215-0036	within 72 ho ine. ihen "natur is Wedical	Completed	15. Decedent's Edu (Specify only highest grad. Elementary/Secondary (0-12) 12 th	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire L Clerk	during most of world	king	16b. Kind of Bu	usiness/Industry Government
Maryland 2	iould be filed within Mental Hygiene. Parked other then patic event, the Matic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Major Thurmond Os	borne			18. Mother's Nam		Maiden Sumam	(e)
ary	2 should and Men Is marke eumatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Town,	State, Zip Code)
	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is eny injury or other treu		Gwennie L. Osborne 20a. Method of Disposition		20b. Place of Dispo	Livings osition (Name of matory or other pla	ton Road	Oxon Hil		20745 City or Town, State
altimore,	Pages ment of h ent: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)		Mt. Rest		8/10	/04	La Plat	a.MD.
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licens				ess of FacilityGeo Hill Rd.			
	Physician /Medical Examiner	Examiner	23a. P.m.1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or Injury	Due to (or as a	ick S		such as cardiac		est,	Approximate Interval Between Onset and Death Con Km o w
.O. Box 6	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	Due to (or as a of the control of th	Fetal death 3	⊒Ectopic pregnanc; □ Other (specify)	у		23d. Date Mon	e of delivery hth Day Year
rds, P	quires tha in signed l	by	Part II. Other significant conditions cor	ntributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.			ibute to the cause of death? 3 Probably 4 Dunknown
al Records,		Completed	Renal Fail	I ream				24a. Was a autops perform	ned? 🔑 d	Vere autopsy findings available rior to completion of cause of eath? ☐ Yes 2 ☐ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth	26. Place of Deat			
of	ding h. After fune	ation: To	27. Manner Death 1 w atural 5 Pending 2 Accident investigation	1 patient 28a. Date of Injury (Month, Day)	28b. Time o	f 28c. Injur Wor	y at	ome 5 Reside 28d. Describe ho		
Division	To the Hospitel or Attenwithin 24 hours after deating the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, sti (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Numbe n, State)	er or Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)	sicien: To the best of ter: On the basis of ex and manner state	camination and/or in	h occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			29c. Licens				(Month, Day, Year)
			1 port	25			5-01	A	u Sist,	6,04
0			30. Name and address of person who co	mpleted cause of dea	th (Item 23a) (Type,	Print) Arast	00 M. Yaz	zdani,M. 20902		
	Sta Registr	_	31. Date filed (Month, Day, Year) AUG 1 1,20	32 Registrar's		Some		· · ·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 750D.M **Physician** Aug 2009 Patricia Anne Pine /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ROSEDALE If Under 1 Year If Under 24 Hrs. Franklin more QUARE 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F Nov. 15, 1947 Maryland 56 Yrs. 220-48-2975 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Evantiner must be notified at Baltimore 1 ☐ Yes 2 ☐ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "any injury or other traumset?" 6 Starwood Court 21220 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify:White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coflege (1-4or 5+) Elementary/Secondary (0-12) Education 2vears School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Wagner Marie Dotterman ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bryan Pine / son 142 Lariat Road Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HollyHillCemetery 8/14/04 Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licenses 300 Mace Ave. Baltimore MD 21221 23a. Part 1. Enter the disease of complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22 Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** X a cerba Sacuratially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed umbn Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 Tes 2 No 3 Probably 4 Nunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case referred medical examiner? To the Hospital or Attanding Physician: 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient ٥ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

4 Homicide

29b. Signature and tiNe of certifier

31. Date fifed (Month, Day, Year) AUG 1 1 2004

30. Name and address of person who pleted cause of death (Item 23a) (Type, Print)

an

29a. Certifier

24 hours a

completely within 24

ical

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-9000

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

LARE DRIVE-BALTI MOTE, Md.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5:30A M ELIZA PETERSON 2004 AUGUSS 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KGSWICK MULTICARE CENTER BALTMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛛 F Yrs. 84 Director 214-30-4428 JUN 15, 1920 VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1XYes 2 ☐ No Director MD NA BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3819 BARRINGTON ROAD Funerai USA 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: AFRICAN Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced AMERICAN Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES ADMINISTRATIVE ASST. 8th Ω ROSEWOOD STATE HOSPITAL it. Pages 1 and 2 should be filed v rtment of Health and Mental Hygie rtent: If item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RICHARD SPENCE SOPHIA SPENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY D. PETERSON (DAUGHTER) 36th STREET BALTIMORE, MD 21218 1510 E. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Deportment of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Bunat 2 ☐ Clemation 5 ☐ Other (Specify ENTOMEMENT WOODLAWN CEMETERY AUG. 14, 2004 BALTIMOLE, MD 22. Name and Address of Facility WYLIE FUNERAL HOME PA 21. Signature of Juneral Service Licensee pode 23a. P. M. Enter the disease, or implications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. 638 N. GILMOR STREET BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition MYOCARDIAL INFARCTION Physician MINUTES resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERY DISEASE DRONALY 45 gals Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 5 Other (specify) the à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 99 icete has been signification of the page 2 should be 1 Yes 2 No 3 Probably 4 WUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? After this certificete 1 ☐ Yes 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending death. 1 □ Yes 2 □ No 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide filled in Hospitel 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29c. License number D 58303 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)

ARXIN J. CHANCES MD CADI N. CHARLES ST BALTIMBRE MO 2/204 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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			Decedent's Name (First, Middle					2. Date of Deat	h	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, o	r Location of Death		4c. County of Dea	th
			9814 CLANFOR			BALTIM			BALTIMO	
	Funeral Director		5. Social Security Number 213 · LA · 1456 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🗗 F	Age (In yrs. last birthda 49 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02-11-10	9. Bii 955	thplace (State or Foreign ountry) SC
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	er de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marri	12. Was Decede Armed Force ed 1 ☐ Yes 2	s?	Was Decedent of F If Yes, specify Cub.	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
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21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28e-1 show he Medical Examiner must be notified at	ted	15. Decedent (Specify only highes	's Education	16a. De	cedent's Usual Occup	pation	ina	16b. Kind of Business	
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Baltimore,	permit. Pagas 1 and Department of Health Important: If itam 27 any injury or othar tr 900.		21. Signal re of Funeral Service	Licensee		22. Name and Addre VAUSHN C. 5151 BAUD	GREENE	FUNERAL E BALT	SERVICE D. MO 21	229
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9	The law requires that the death certificate be executed ate bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Мес	IF FEMALE:	23c. If yes, outcon	me of pregnancy				204 Date -44	P
Box	atten	by Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date of de Month	Day Year
0	that the de	Jysi	1 □ Yes 2 2 No 9 □ Unknown	9□ Unknown						
Д,	res that igned b	y PI	Part II. Other significant condition	ns contributing to death	h but not resulting in the	e underlying cause gr	en in Part I.	23e. Did tob	acco use contribute t	the cause of death?
ıdş	w require been sig should b			****				1 □ Ye	s 2. No 3 □ P	robably 4 Dunknown
Records,	law re as be 2 sho	Completed						24a. Was ar	n 24b. Were a	utopsy findings available completion of cause of
- R	The cate h	Con						perform	ned? death? 1☐Yes	completion of cause of
Vita	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		O#		h (Check only one		Daughter's
of Vital	Phys r this ral dir	To.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpa			ner: 4 ☐ Nursing Ho		once EXX Other (Special of the control of the cont	Residence
On	Attending or death. actor: After by the fune	tlon	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, I	Day Year) Injur	y Wo	rk? Yes 2 ☐ No			1502 R480 R640 R440 A
Division	Atter r dea actor by the	ifica	3 Suicide 6 Could a 4 Homicide determ	286. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office		28f. Location (Str. City or Town	reet and Number or R	ural Route Number.
Ö	s after all Dirac	Certification;	4 Homicide	building,	etc. (Specify)			City of Town	, Siale)	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page.	edical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the be Examiner: On the basis and manner	s of examination and/or	eath occurred at the tid r investigation, in my o	me, date and place, ppinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To tha within 2 To the comple	Me	29b. Signature and title of certifie	- 00		29c. Licens	se number	29	9d. Date signed (Mon	th. Day, Year)
			> Stim 1	men Mo		DY	3152		AUGUST	5,2004
	1.7		30. Name and address of person	· ·		De, Print) True M	# 135	Salto,	MD 2120	
	Sta		31. Date filed (Month, Day, Year)	32. Regi	istrar's Signature	1	,			
	Regist	rar	AUG 1 1,20	U4 200	10	sports				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2004

AUG 1

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Dealtr **Physician** Day 05 Month Year Darletta Parsons : 25 am M Hugust 2004 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Mem. Hospital Baltimore NA 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 ☐ M 2 🂢 F 213-90-4815 Director Yrs. 40 6-18-64 Md. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits treumatic event, it is Madical Examiner must be notified at Director X□Yes 2□No Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 4926 Frankford Ave. 21206 or Items 23e USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No ģ Specify: Black 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade ges 1 and 2 should be filed vit of Health and Mental Hygie Assistant Teacher Purpose & Protential 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Parsons Phyllis Matthews ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Fisher Mother 4311 Springwood Ave., Baltimore, Md. other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō permit. Page Department of Important: If any injury or once. 8-10-04 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 Janes March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (F disease or condition resulting in death) nmediate Cause (Final **Physician** End Stage Aguired immunoactivency syndrome 4 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending population of the control of the cont IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by should be 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 1 Yes 2 No Division of Vital Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No inpatient 2 ER/Outpatient 3 □ DOA P this funeral 28c. Injury at Work? Certification: 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural death. I Director: A 1 Tyes 2 □ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifiei and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) handa Boll, ND AT2438946 August 05, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chanda Bell, MD 201 E. University Parkway Baltimas MD 21218 31. Date filed (Month, Day, Year) AUG 1 1 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State	e of Maryland				-	•	ie.	
			State	e or maryland		tificate of l					
\			Registrar 1. Decedent's Name (First, Middle, Last)		001	incate of t	Dealit	2. Date of Dea	eg. No. 2	3 Time of Death	5
	Physici	an						Month	Day Y	/ear	
	/Medic		Margaret A. Pulle: 4a. Facility Name (If not institution, give street ar			4b. City. Town, or	r Location of Death	August	8, 200 4c. County of		
5	Examin	er	Carroll Hospital Cer				inster			rroll	
7	Funeral		Social Security Number	7. Age (In yrs. Ia	ist birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplece (State or Foreig Country)	gn .
Z	Director		218-42-9974	KF 61	Yrs.	Months Days	Hours Min.	Nov. 7	1942	MD	
_	D .		Usual Residence of Decedent 10a. State 10b. County	100 City	, Town or Lo	nation				10d. Inside City Limits	
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\mathcal{Z}	death with the Maryland ms 23a or 28a-f ehow r must be notified at	ect	MD Baltimore 10e. Street and Number		Owin	gs Mills			l0g. Citizen of Wh		
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\$	Jeath Trs 23	era	3 H Green Mountain Co	Decedent Ever in U.S	3. 13. V	21117 Vas Decedent of H	lispanic Origin? (Spo an, Mexican, Puerto	ecity Yes or No-		SA - American Indian,	_
X MNDEN 6	ia ≥ ₹	Ē		ed Forces? Yes 2 7 No es, Give X				Rican, etc.)		White, etc.	
16 X	hours after tural, or ite	d by	3 ☐ Widowed 4 ▼ Divorced Yea	r or Dates:		□Yes 2√2 No	Specify:		Specify:	White	
200	72 hours "natural",	ete	15. Decedent's Education (Specify only highest grade compl	eted)	16a. Deced (Give	ent's Usual Occupa	ation during most of works d)	ng	16b. Kind of Busi	ness/Industry	
7 5	d within 72 piene. ir then "nai	Completed by Funeral Director	Elementary/Secondary (0-12) Coll 12	ege (1-4or 5+)		e Worker			Cleri	o o 1	
d 21	S 57 S	Ö	17. Father's Name (First, Middle, Last)		OILIC	e worker	18. Mother's Name	(First, Middle,			
In E	id be ental ked c	To Be	George Issac				Dorot	ny Haves	2		
S	2 should be f n and Mental P is marked of raumatic ever	-	19a. Informant's Name/Relationship (Type, Print	t)	19b. Mailin	g Address (Street a	and Number or Rura			tate, Zip Code)	
₹ ≥	es 1 and 2 should to Health and Ment 1 item 27 is marked in other traumatics		John Puller	Son	6 Mo	rris Wav	Road, Ow	ings Mil	Lls. MD 2	21117	
LARCARET	of He		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal	CO	ace of Dispo:	sition (Name of natory or other place	, ,	Date	20c. Location - C	ity or Town, Stete	
3 E	permit. Pages Department of Importent: If it eny injury or o		`4 □ Donation 5 □ Other (Specify)		e View	Mem. Par	rk 8/10	/04	Sykesvi	lle, MD	
Zatt	ermit. epart nport ny inj		21. Signature of Funeral Service Licensee	0. 11	, 22	. Name and Addres	ss ol Facility	11824	Reisters	stown Road	
6.	<u>0</u> 05 € 0		supher 111.	Jenas		ine Funer				MD 21136	
			23a. Part1. Enter the disease, or complications shock, or heart lailure. List only one cause	e on each line	. Do not enti					Approximate Interval Between Onset and Death	
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- 1	Examiner		8	ue to (or as a consequ	ence of):						
K	2	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequ	ence of):						
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Bo	eath certification attending processes as	cian	in the past 12 months?	Live birth 2 Fetal Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		23d. Date Monti		
Ö	at the de by the	nysi		Unknown		,					
٠,	res that igned t	by P	Part II. Other significant conditions contribution					23e. Did to	bacco use contrib	oute to the cause of death?	
rds	w require been sig	edt	SVIERIOR VE	NA C	IVA	2910.	DRO ME	1 □ Y	es 2□No 3	Probably 4 Unknown	n
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Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			0#	26. Place of Deat	(Check only or	10)		
ţ,	Phys this ral dir	-T	I Tes ZE NO	1 Inpatient 2 1	Proutpation 28b. Time of		4 Nursing Ho		ence 6 Other		
no	ding f th. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury (Month, Day Yeer)	Injury	Wor	k? Yes 2 □No		on agery coodings		
Division of Vital Records. P.O. Box 68	or Attendi after death. Director: A in by the fi	Ifica	o Clair Could not be	Place of Injury - At ho	me, farm, str	eet, factory, office				or Rural Route Number,	
Ö	s after el Direc ed in by	Certification:	4 Hollincide	building, etc. (Specify	,			City or Tow	n, State)		
	To the Hospitel or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the tuneral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physician: (Check only) 2 Medical Examiner: On	To the best of my know	wledge, death	occurred at the tin	me, date and place,	and due to the c	ause(s) and manr	her as stated.	
	the hin 24 the B	Medical	one) and	manner stated.					-		
	To To		29b. Signature and title of certifier	1 10. M	M	29c. Licens	529 x		C G	(Month, Day, Year)	
			30 Name and additions of account	dequipe of decit (ii-	2201/7	Drint)	2210		0/1/	7	
1	\		30. Name and address of person who complete	d cause of death (Item		STMIN	SIER	MD	5	1157	
1	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signal	ure	4 1	1.				
	Regist	rar	AUG I I ZUU4	peren	1	good	KS				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ausus Year Doso The 50 PM 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death BKLTIMORE, MD Baltimore MARINER HEALTH DF OVERLEA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 1□ M 2□ F 83 216-18-3014 05/12/1921 | Faryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3720 Springwood Avenue 21206 USA Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Factory Worker Western Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elmer Preston Eva White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Wilkerson/Niece 3720 Springwood Avenue Baltimore Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith 8/10/04 Baltimore Maryland 21. Signature of Funeral Service License Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) bacco use contribute to the cause of death? es 2 No 3 Probably A Unknown 24b. Were autopsy findings available prior to completion of cause of death? n autopsy ned? 2 No 1 ☐ Yes 2 No

Physician /Medical Examiner

attending physician and

Depertment of Health e Important: If item 27 Is eny Injury or other treu once.

Physician

/Medical

Examiner

10a State

Funeral

Director

Pages 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mental Hygiene. Int: If item 27 is marked other than "netural; or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

7 is markad other than "natural", or itema 23a or 28a-f shoi treumatic evant, the Medical Expuriest must be notified at

Funeral Director

Completed by

Be

Completed by Be

Physician/Medical Examiner Certification: To Medicai

29a. Certifie

or Attending Physician: The law requires that the death certificete be executed

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):	
that initiated events resulting in death) Last	Due to (c	or as a consequence of)	:	
•	■ d.			
Part II. Other significant conditions	s contributing to death but not res	sulting in the underlying	cause given in Part I.	23b. Did to
				1 □ Y€
				24a. Was ar perform
				1 ☐ Ye
25. Was case referred to medical examiner?				eath (Check only one
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ D	OA Other: 4 Nursing	Home 5□ Reside
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day Year) tion	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho
3 ☐ Suicide 6 ☐ Could not determine		ome, farm, street, facto	ry, office	28f. Location (St. City or Town

26. Plece of De	eath (Check only one)
Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
fice	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physic	ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(and manner stated.

	(Check only &	Medical Examiner: On the ba and mann	sis of examination and/or investigation, in my opinio er stated.	on, death occurred at the time, date and place, and du
9b	. Signature and title	of certifier	2elace D 306	mber 29d. Date signed (Mor

Below Rd, Baltinore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6//6 21206. Tri puraneni

32. Registrer's Signature

State Registrar

erel Director: After filled in by the funer

To the Hospital within 24 hours e To the Funerel I

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			1_ State	State of Marylan			of Health of Death		, ,		0001	
			Registrar 1. Decedent's Name (First, Middle, Last)		00	imeate	Or Dodin		2. Date of Dea	Reg. No.	1000	3: Time of Death
	Physici		Albert William	n Price					Month August	10.	2004	4:15 A M
	/Medic Examir		4a. Facility Name (If not institution, give str			4b. City, To	wn, or Location				County of Dea	
	- 1848 · Mg		Stella Maris Hospi			Timon					altimor	
	Funeral Director		5. Social Security Number 6. Sex 1203-01-1085	7. Age (In yrs. 84		If Under 1 \		Min.	B. Date of Birth (Month, Day May 11)	, Year) 19:	9. Bir Co Per	thplace (State or Foreign buntry)
	pg &		Usual Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	veation						10d. Inside City Limits
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	r 28e-	Funeral Director	10e. Street and Number	Der	ALL	10f. Zip Co	ode		1	10g. Citiz	zen of What Co	ountry?
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Ħ	r dea	ner	11. Maritat Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deceden	t of Hispanic C Cuban, Mexica	rigin? (Specan, Puerto R	ify Yes or No- ican, etc.)		14. Race - Ame Black, Whi	
	72 hours after death with the Marylan "naturel", or Hems 23a or 28e-1 show edical Examinativant be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Wivorced	1X Yes 2 □ No If Yes, Give Year or Dates: WWI	т	1□Yes 2X	No Specify	y:			Specify: Wh	ite
4:15 15-00	72 hou 'nature	ted	15. Decedent's Educa (Specify only highest grade	ation	16a, Dece	dent's Usual C	Occupation	as of markin.		16b. Kir	nd of Business	
4 215	within 7 ene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use i	retired)		,			
√ ⁴	be filed withir ital Hygiene. od other then		12 17. Father's Name (First, Middle, Last)		Tool	and Di	e Maker		First, Middle,			ntractor
10, 2004 4:15 a Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, trems	To Be	Albert (nmn)	Price				elia	nrar (nrar		Krop	oa.
ary .	ges 1 end 2 should t of Health and Men if Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (S	treet and Num	ber or Rural	Route Number	r, City or		
	end 2 salth a 27 is		Albert W. Price, Jr	c Son	2719	Bynum	Hills (Circle	, Bel A	Air,	Maryla	nd 21015
AUGUST altimore,	of He of He of He of oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 remation 3 ☐ Re		lace of Dispo emetery, cre	osition (Name matory or othe	of or place)	Da		20c. Lo	cation - City or	Town, State
uga Ei	Peg tment tant:		4 Donation 5 Other (Specify)	Hil		Serv. C		8-11-			son, Ma	
ABal	permit. Peges 1 end 2 Department of Health 3 Important: if Item 27 is any Injury or other tra once.		21. Sign ure of Funeral Service Licensee	1 1			Address of Faci kesbury					e, P.A. and 21009
	*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	n. Do not en	ter the mode o	of dying, such a	s cardiac or	respiratory arr	rest,		Approximate Interval Between Onset and Death
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8760,	ate hys	dicai	d.			·		-				
9 X 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna						,	3d. Date of de	ivery
Вох	death e atter d for u	by Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d		⊒Ectopic pregi ⊒ Other (s <i>peci</i>		<u> </u>		1	Month	Day Year
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	The law requires that the death certific te has been signed by the atlending p	by F	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying caus	se given in Parl	: 1 .		bacco us		o the cause of death?
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ш.	The law ate has page 2 s	Completed							24a. Was a autops perfor	sy	deatn?	topsy findings available completion of cause of
RT	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26 Pla	on of Death	1 ☐ Yes Check only or	2 No	1 ☐ Yes	2 No
ALBERT of Vital	Physician: this certific ral director,	ToB	examiner?	ospital:	ER/Outpaties	nt 3 DOA	Othor				Y her (Spe	city) HOSPICE
		L:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c.	Injury at Work?		d. Describe h			" INSTITUTE
Siol	Attending r death.	catic	2 Accident investigation			М	1 Yes 2					
Division	늘 를 들 드	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tnjury - At ho building, etc. (Specify	ome, farm, st	reet, factory, o	ffice	28	8f. Location (Si City or Town		l Number or Ri	ural Route Number,
	중문 교실 교	edical C	29a. Certifier (Check only one)	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the vestigation, in	the time, date a my opinion, de	and place, ar	nd due to the c	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier			29c. L	icense number		2	29d. Date	signed (Mont	h, Dey, Year)
			/2				1437	25			5/10/	04
.61			30. Name and address of person who con									
17	C.	ate	DR. TARIQ MAHMOO 31. Date filed (Month, Day, Year)	D 2300 DULAN 32. Registrar's Signa		LLEY RI). TIM	MUINC,	MD 210	093		
	Regist	ate rar	NUC 1 1 2004	herman	4	Arson set						

		4	For State C		artment of Health and ertificate of Death	Mental Hygie	Z 11 1 1 ts	25239
			1 Decedent's Name (First Middle, Last)			2. Date of Death Month	Day Yeer	3. Time of Death
	Physicia /Medic		Irene N. P.	oilard.		Month 8	6 04	1 "
7	Examin		4a. Fecility Name (If not institution, give street and no		4b. City, Town, or Location of Deal	h	4c. County of Death	
			Hart Heritage Est	7. Age (In yrs. last birthday	Street M. O.	R Date of Birth	Harfos	nplece (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M 2015	7. Age (in yrs. last birthday 93 Yrs.	Months Days Hours Min		1911 New	Intry) 7 York
		-	Usuel Residence of Decedent	10				
	yland		10a. State 10b. County	10c. City, Town or t	ocation			10d. Inside City Limits
	e Maria	ctor	Maryland Harford	Bel Air				1 ☐ Yes 2 MÃNo
	or 28	Dire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cor	untry?
	ath w	rai	300 West Ring Factory Ro		21014		SA 14. Race - Amer	ican Indian
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show important: if item 27 is marked other than "naturel", or items 23e or 28e-f show all high right into their traumatic event, the Medical Exatt are could be notified at ance.	by Funeral Directo	Armed F	orces? 210 No ive	. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puel 1 ☐ Yes 2√2 No Specify:	to Rican, etc.)	Black, White	e, etc.
21215-0036	2 hou	ted	15. Decedent's Education	16a. Dec	edent's Usual Occupation		b. Kind of Business/I	nite Industry
215	hin 7.	ple	(Specify only highest grade completed Elementary/Secondary (0-12) College		e kind of work done during most of wo DO NOT use retired)	nking		
N	giene giene	Completed	5-	0 1	ol Teacher		ublic Edu	cation
nd	be filed tal Hygi d other event, I	B	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		
y a	should be find Mental I	2	William N. N: 19a. Informant's Name/Relationship (Type, Print)	icholson	Alice ling Address (Street and Number or A	Eliza		Hewlett
Maryland	12 st th and 7 is n traun	-			Briarcliff Drive,			
	is 1 and 2 of Health a item 27 is other trai	1	20a. Method of Disposition	20b. Place of Disa	position (Name of		c. Location - City or	
nor	Pages nent of int: If it		1 ☑Bunal /2 ☐Cremation 3 ☐Removal from	1 State	ematory or other place) ollow Cem. 8/13	L/04 Sl	eepv Holl	ow, New York
Baltimore,	permit. Page Department of Important: If eny injury or 2002.		21. Signature of the Spervice Lizensee		22. Name and Address of Facility	McComas Fi		
B	Departiment of the particular in the particular		Wall aster		1317 Cokesbury Ro	oad, Abingo	don, Mary!	Land 21009
ĸ,			23a Part Enter the disease, or complications that	caused the death. Do not e each line.	nter the mode of dying, such as cardia	ac or respiratory arrest	.,	Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Dementia	_			Onset and Death
	/Medical		resulting in death)	(or as a consequence of):				
и	Examiner	Ļ	Sequentially list conditions, if any, leading to immediate	/				
	ed sit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):				
	be executed ician and burial-transit	xan	that initiated events c	o (or as a consequence of):				
8760,	cate be executed only sician and the burial-transit		L _a					
Ö	g phys	Physician/Medical						
Вох	death certifica e attending ph d for use as th	M/UE	23b. was decedent pregnant	utcome of pregnancy birth 2 Tetel death 3	I □Ectopic pregnancy		23d. Date of deli	ivery Day Year
	ne deat the att hed for	sicie	in the past 12 months?	gnant at time of death	Other (specify)		MORIT	Day real
P.0	± ≥ ∞	Phy	9 ☐ Unknowh Part II. Other significant conditions contributing to		underlying cause given in Part I	23e Did toba	cco use contribute to	the cause of death?
	w requires that been signed to should be deta	by	Chronic renal	insufficier			2 □ No 3 □ Pr	
Ö	law requires as been sign 2 should be	etec	CVINORIO VERNE	101 5000 1100		24a. Was en	24h Were au	itopsy findings available
Rec	has pe 2	Completed				autopsy	prior to death?	completion of cause of
Vital Records,		e Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 eath (Check only one)	ZNo 1 ☐ Yes	2 No
	Physician: this certificant	0 8	examiner? Hospital:	Inpatient 2 ER/Outpat	Other	Home 5 ☐ Residen	ce 6 Dother (Spe	city) Assisted
1 of		n: T	27. Manper of Death 28a. Dat	e of Injury 28b. Time		28d. Describe how	injury occurred	3
ior	death. ctor: After y the funer	atlo	2 Accident investigation		M 1 Yes 2 No			
Division		Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, iding, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	To the Hospitel or / within 24 hours after To the Funeral Dire completely filted in b		29a. Certifier 1 Certifying Physician: To t	he hast of my knowledge de	ath occurred at the time, date and place	e and due to the cau	se(s) and manner as	stated
	Hos 24 ho Fun etely	Medical	(Check only 2 Medical Examiner: On the	basis of examination and/or inner stated.	investigation, in my opinion, death oc	curred at the time, date	e and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number	290	d. Date signed (Mont	h, Day, Year)
	F > F 0		I halu Ginn	us nus	D53186		08/09/0	4
n,			30. Name and address of person who completed ca	use of death (Item 23a) (Typ	e. Print)	. 5		
1	`		Julie Tinney		w. McPhail Ro	L 13e/ A	or MD	21014
	St Regist	ate	31. Date filed (Month, Day, Year) 32 AUG 1 1 2004	Registrar's Signature				
	negisi	1140	AUD I / AND / CO	There is	An- We			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** August 2004 5:35 P M Υ. RIENHOFF /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **X** 2□ F 577-44-3814 76 Director BALTIMORE, MD FEB 8, 1928 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examination instituted at 1 ☐ Yes 2√XNo Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6605 WEYMOUTH COURT 21212 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? XXYes 2 ☐ No Black, White, etc. 1 and 2 should be filed within 72 hours after or teatth and Mental Hygiene. 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: WHITE þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced KOREA Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEERING 5+ PAPER MILLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK UNK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trai ANNE B. RIENHOFF - WIFE 6605 WEYMOUTH COURT, BALTIMORE, MARYLAND 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 📉 💢 emation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funder Section 1. BAYVIEW CREMATORY 8/7/2004 BALTIMORE, MD 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT MNK #M01148 KELLY GREGORY 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CERESTONNIALEN Arcident Priysician disease or condition resulting in death) /Medical Vascular Isserre **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the burial-transit certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Dav 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ cancer nech, Sp ndiation Therage 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital I or Attanding Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို the funeral 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide To the Hospital or Atta within 24 hours after de To tha Funaral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier

Hedelly Melan II 40 29d. Date signed (Month, Day, Year) 29c. License number who completed cause of death (Item 23a) (Type, Brint) ST BATIMORS MO ZIZIZ 30 Name and address or person.
TUBLELL W TYLEHM? 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2004 Registrar

			For State Registrar	Sta	ate of I	Maryland	•	artment tificate			and M	ental Hy	giene Reg. No. (004	2524	
	Dhusiai		1. Decedent's Name (First, Middle	e, Last)								2. Date of Dea Month	Day	Year	3. Time of D	
	Physicia /Medic	al .	Helen			uther						August			5:25 A	M
	Examin	er	4a. Facility Name (If not institution		and numb	er)				Location o	f Death		1	ounty of Death		
			66 Hopewell Co		1-	A-a /la una la	na biodonio (1	Port If Under		oosit Under:	24 Hrs	8. Date of Birt		Cecil C		C /
	Funeral Director		5. Social Security Number 214-38-5864	6. Sex 1 ☐ M :		Age (In yrs. Ia 61	Yrs.	Months	Days	Hours	Min.	(Month, Day	v, Year)	Cou	place <i>(State or F</i> ntry) ryland	roreign
	pu 💌	-	Usual Residence of Decedent 10a, State 10b, County			10c City	Town or Lo	cation							10d. Inside City	Limits
	sho	5	Tou. Glaid			100.01,									1 ☐ Yes 2	
	the N 28a-f cuifi	ect	Maryland Ce	cil				10f. Zip		Dep	osit		10g Citize	n of What Cou	intov?	
	a or	ij		701174				101. 2.0	0000	219	04			ted St		
	eath	era	66 Hopewell (12. W	as Decede	ent Ever in U.S	. 13.	Was Deced	lent of Hi			cify Yes or No Rican, etc.)		Race - Amer		
36	72 hours after death with the Maryland natural; or Itams 23e or 28e-f show lical Eranis et must be rolified at	by Funeral Director	1 □ Never Married 2 □ Mar 3 □ Widowed 4 ☑ Divorced	ned 1	med Force Yes 2 Yes, Give ear or Date	es? ☑No		fYes, spec 1 ☐ Yes 2			, Puerto I	Rican, etc.)		Black, White pecify:	white	
21215-0036	be filed within 72 hours ital Hygiene. Ind other than "natural", evant, the Medical Exe	edi	15. Deceder	t's Education	1		16a. Dece	dent's Usua	al Occupa	ation			16b. Kind	of Business/I	ndustry	
15	nin 72	plet	(Specify only higher Elementary/Secondary (0-12)		npleted) ollege (1-4	or 5+)	(Give life.	kind of wor DO NOT us	rk done d se retired	luring mosi)	t of worki	ng				
212	filed within Hygiene. other than "	Completed	10 Years		onege (1-4	01 34)	Fa	ctory	y Wo	rker_			Su	burban	Plastic	cs
	il Hygie other	Bec	17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)		
lar	should be od Menta marked	TO E	Roy Childres	5						М	arga:	ret Hie	m			
Maryland	S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relations		. '			-				I Route Numbe				04
	5 = 7 = 1			farr	/ So		to to Dispo			Cour		ort Dep			and 2190	
Baltimore,	Pages 1 ar ent of Hea nt: If itam ry or otha		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		al from St	ate ce	metery, crei k Lawr	natory or o	ther plac	1 1 .	9/20			tion - City or T		
Balti	permit. Pages Department of h Important: If its any injury or of		21. Signatur 1 Funeral Service	Licensee	0		Ι		Ruck	Fune	ral 1	Home of				
			23a. Part1. Enter Me disease, o	r complicatio	ns that cau	sed the death.	Do not ent	922 W	ise le of dvin	Ave. g. such as	Dur cardiac o	ndalk, I	Mary La rest.	and 21	222 Approximate	
N.	Pnysician /Medical		shock, or head failure. Lis Immediate Cause (Final disease or condition resulting in death)	only one ca	Lu.	ng Ca	ince	r						141	Interval Betwee	ath
	Examiner		0 11 5 1 15				,									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clause of The Cause)	Į "-	Due to (or	as a conseque	ence of):								-	
	and -trans	Examiner	that initiated events resulting in death) Last	С.	Due to (or	as a conseque	ence of):									
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687	tificate og phys as the	dic		d												
O. Box	eath cer attendir for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	1 4	Live birt	ome of pregnan h 2 Fetal nt at time of de m	death 3[⊒Ectopic pr ⊒ Other (sp					230	d. Date of deliv Month	rery Day Ye	ar
σ.	uires that the d signed by the lid be detached	by	Part II. Other significant condit	ons contribu	ting to dea	th but not resu	lting in the u	nderlying c	ause giv	en in Part I		23e. Did to			the cause of dea	
Records,	0 4 0	Completed										24a. Was autor perfo 1 Typs		24b. Were aut prior to codeath?	opsy findings av	railable use of
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical	ul					_	26. Place	of Death	(Check only o				
>	Z S	To B	examiner? 1 Tes 2 No	Hospi	tal: 1 🔲 Ing	oatient 2 🗆 E	R/Outpatie	nt 3 DC	Oth Oth	өг: 4 □ Nu	ırsing Ho	me 5 Resid	dence 6[☐Other (Spec	ity)	
n of	ding Ph J. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pendi	28	Ba. Date of (Month,	Injury Day Year)	28b. Time o Injury	f 2	8c. Injun Wor	/ at k?		28d. Describe I	now injury o	occurred		
Sio	Attending in death. ector: After by the fune	cati	2 Accident invest	igation				M		Yes 2□						
Division	al or Att	Certification;	3 Suicide 6 Could 4 Homicide deten	nined 28	Be. Place o building	f Injury - At hor g, etc. (Specify,	ne, Jarm, st)	reet, lactory	y, office			28f. Location (S City or Tox		Vu <i>mber or R</i> ui	al Route Numbe	91,
	To the Hospital or Attending Phwithin 24 hours after death. To tha Funeral Director: After the completely filled in by the funeral	edical C	29a. Certifier (Check only one) 2 Medica	Examiner:	n: To the b On the bas and manne	is of examinati	vledge, deat ion and/or in	h occurred vestigation	at the tin	ne, date an pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certific	er A	2 /			290	c. Licens	e number			29d. Date	signed (Month	Day, Year)	
			Karen	X.6	inte	1 MD) .		L	5/3	520	/	08	5/06/	04	
9			30. Name and address of person	who comple	20	of death (Item			Por	+ De	posi	+, MD	219	904		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year	1112		gistrar's Signat	ure	G	Sp	aks	/		•			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2004 Jeannette Blake Reed July 31 1:15 PM^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Min. (Month, Day, Year) March 26, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 1□M 2□F 577-30-2308 1922 Director WDC Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f ehow Exeminer ment be notified at 1∏Yes 2□No Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6701 Luzon Avenue N.W. 20011 U.S.A. deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Heelth end Mental Hygiene and History 12 is marked other than "natural", or lies any or other traumatic event, the Mental Executed by or other traumatic event, the Mental Executed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Secondary (0-12)}}{12th}$ College (1-4or 5+) Goverment employee DC Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rudolph Blake Ida Brown 2 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Y. Bradley -Conservator) 300 Decatur ST, NW WDC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Riverdale Crematory 8/4/04 Riverdale, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Li 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Luse (Final disease or condition N.W. WDC 20011 pproximate iterval Between Inset and Death **Physician** Lung Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trail Due to (or as a consequence of): Box 68760 physicien Physician/Medical as the attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy to in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ģ Division of Vital Records, P. signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 Yes 2X No 3 Probably 4 Unknown Completed Hypertension peen Diabetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an autopsy performed? certificate 2**%** No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined within 24 hours after To the Funerel Direct 4 Thomicide tilled Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certified Medical only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the ature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Sig ္ > MAMIM D59284 8/04/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shahid Shamim M.D. Holy Cross Hospital, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) AUG 1 1 2004 32. Registra's Signature State Registrar

				For State Registrar		State o	f Maryla		epartment Certificate			Mental Hy	giene	1001	2521.3
				1. Decedent's Name	(First, Middle, La	ist)	_				-	2. Date of D	eath		3. Time of Death
		Physici /Medio		GELIST	FR	SPEIGHT						Month AUG. 9.	2004	,	9:25 am M
		Examin		4a. Facility Name (If			m <i>ber</i>)		4b. City, T	own, or	Location of Death			. County of Death	
				JOSEPH	RICHIE	HOSPICE]	BALTI	IMORE			NA	
		Funeral		5. Social Security No	umber 6.	Sex 10X1M 2□F	7. Age (In yi		hday) If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Year,	9. Birth	nplace (State or Foreign
		Director		577-18-0325		ILALM ZLIF		34 `	Yrs.	,.		SEPT. 7	, 191	9	NC
		and *		Usual Residence of 10a. State	10b. County		10c.	City, Town	or Location						10d. Inside City Limits
		harylan I show	ō												1 X Yes 2 □ No
		the N	Director	MD 10e. Street and Nun	NA NA			BA	LTIMORE 10f. Zip 0	Code			10a Ci	tizen of What Co	intai?
		a or							101. Zip 0				109.01		and y
		ns 23	Funeral	1907 11. Marital Status	PAYSON ST	REET 12. Was Dec	edent Ever in	u.S.	13. Was Decede		L217 spanic Origin? (Si	pecify Yes or N	0.	USA 14. Race - Amer	ican Indian.
	10	riten riten	표		ed 2 Married	Armed Fo	rces?				spanic Origin? (S n, Mexican, Puert	o Rican, etc.)		Black, White	
	21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "naturel", or items 23a or 28a-1 show other than "naturel", or items 23a or 28a-1 show event, the Medical Examinar must be notified at	by	3 Widowed		If Yes, Gir Year or D	ve		1 ☐ Yes 2	X No	Specify:			Specify:	RICAN
	Ō	2 ho	Completed	/Snan	15. Decedent's E	ducation		16a.	Decedent's Usual		ation during most of wor	kina	16b. F	(ind of Business/I	
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	nd	d oth	Be	17. Father's Name (First, Middle, Las	t)				1	18. Mother's Nan	ne (First, Middle	e, Maider	n Sumame)	
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7	Maryland	d 2 should th and Men 7 ie marke traumatic		19a. Informant's Na				19b.	Mailing Address (Street a			ber, City	or Town, State, Z	îp Code)
10		s 1 and of Health item 27 other tr		ODELL JOH		TER)	201		7 WOODSIDE Disposition (Name		AD BALTIM	DRE, MD	21208		F Ct
7	O.	S to I		20a. Method of Disp 1XXBurial 2	osition Cremation 3 [☐Removal from	State	cemeter	y, crematory or oth	er place	1			ocation - City or	
	altimore,	t. Pa tmen tent: ijury			5 Other (Speci		M	r. ZIO	M CEMETERY			L4, 2004	-	SDOWNE, MI)
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7						one cause on	ach line.	Baul. Dol	not enter the mode	Or dynn	g, such as cardiac	or respiratory	arrost,		Interval Between Onset and Death
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~			آة.	Sequentially list con if any, leading to im	nditions, mediate	b. Due to	(or as a cons	sequence o	of):						
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7	9	death certificate e attending phys id for use as the	fedi												
5	ŏ	death certifica attending pl d for use as t	Jug V	IF FEMALE: 23b. Was decedent		23c. If yes, ou 1□Live I	tcome of pre-		3 □Ectopic pre	onancy				23d. Date of deli	*
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V)	Ś	igned bed	b	Part II. Other signif	we by d	1		resulting in	the underlying ca	use give	en in Part I.				the cause of death?
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2		The sate t	Son									peri 1 ☐ Yes	formed?	death?	2 1 No
5	of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Be	25. Was case refer examiner?	red to medical	Hea-'t-'					26. Place of Dea	th (Check only	one)		
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(1	sio	tend leath tor: /	cat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not	ho -			М		Yes 2 No	004 1	/D4	and Alicenters of Co.	-10
	Division	or At fter o Direction by	Certification:	4 Homicide	determine	4 288. Place	e of Injury · A ling, etc. (Spe	it nome, ta ecify)	rm, street, factory,	office		City or To	own, Stat	e)	ral Route Number,
		pitel ours a erei i		29a, Certifier	10 Cartifying P	hysician: To the	a bast of mu	knowledge	, death occurred a	t the tim	o date and place	and due to the	2 021150/6) and manner as	etatod
		Hos 24 hc Fun stely	edical	(Check only one)	2 Medical Exa	miner: On the b	pasis of exam oner stated.	ination an	d/or investigation, i	in my or	pinion, death occu	rred at the time	, date an	d place, and due	to the cause(s)
		o the	Me	29b. Signature and	itle of certifier				729c.	License	number		29d, D	ite signed (Month	, Day, Year)
		F S F O			. 120	173			D	24	321		81	9/04	
		1		30. Name and addr	ess of person who	pompleted cau	se of death (i	Item 23a)	(Type, Print) .	_		0	-	4.	ΛΛ Ι
		V (Ph	P		7 5	8	21 N.S	thi	tau St.	Balti	mai	21201	140
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month AUGUST 9, MARCELLA F. SCHULTZ 2004 7:00 PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12401 LIME KILN ROAD **FULTON** HOWARD COUNTY tf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 00/27/1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M X2X F 40 318-05-0008 CHICAGO, Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2XXVo Director FULTON MD HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23a or 12401 LIME KILN ROAD 20759 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. e filed within 72 hours after al Hygiene. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) CLERICAL MANUFACTURING 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANK SCHULTZ BERTHA (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIMOTHY STEWART - NEPHEW 19404 WEYMOUTH DRIVE, LAND O LAKES, FLORIDA 34638 20a. Method of Disposition
1 ☑ Surial 2 ☐ Cremation ※XXRemoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State UNK * 4 Donation 5 Other (Specify) ST. MARYS CEM. EVERGREEN PARK, IL 21. Signal life of Funeral Service Light KELLY GREGORY FINK 22. Name and Address of Facility MARYLAND MORTUARY SUPPORT 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 #M01148 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, cheart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) Physician 2 MOS /Medical Due to (or as a consequence of) Examiner remention Sequentially list conditions, it any, loading to infinitelliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or se a consequence of) Examiner attending physician and for use as the burial-transit A Due to (or as a consequence of): Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy detached for in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 ☐ Yes 2 X No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 2 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No or Attend after death Director: / the * 2 Accident 6 Could not be determined 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) August 11, 2004 NO 30. Name and Press of person who completed cause of death (Item 23a) (Type, Print) Randal Riesett 10100 Chinter Dr COLUMBE NO SIDIY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 1 2004

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 0:00AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner MAYK 10 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1 □ M 2 F Hours Min _534 Decedent Yrs. Director Usual Residence of with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show traumatic event, the Medical Exandrar must be notified at 1 Yes 2 No by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 06 deeth permit. Pages 1 and 2 should be filed within 72 hours atter dee. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" or item once. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, reewa 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address a Facility 2106 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia - Cause (Final disease or condition resulting in death) ANTEN ONONTE **Physician** /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran Due to (or as a consequence of): attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. | à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be 2 No 3 Probably 4 DUnknown 1 Yes Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Yes 2 No 3□ DOA 2 FR/Outpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 1 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NNAFOLIS RE 31. Date filed (Month. Day, Year) 32. Registrar's Signature State Registrar Dalla

	Registrar		Properties Health and ertificate of Death	Reg. No	who also as a contract of
Physician /Medical	Decedent's Name (First, Middle, Last, Charles L 4a. Facility Name (If not institution, give	. Smith	4b. City, Town, or Location of Deat		2004 1:26A ^M
Examiner	P.G. County Hos 5. Social Security Number 6. Se:	pital	Cheverly		P.G.
Funeral Director		M 2□F 65 Yrs.	Months Days Hours Min.	8. Date of Birth 3/4 (Month, Day, Year)	/39 9. Birthplace (State or Foreigr Od Virginia
e-f show	MD P.G.	10c. City, Town or Cap:	itol Heights		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
offer death with the Mainter death with the Mainter to 188-1 so I will be notified in the mainter of the mainter of the Mainte	10e. Street and Number 9403 Dogwood Pa	rk ST.	10f. Zip Code 20743		tizen of What Country?
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filed within 72 hor Hygiene. Ither than "natura int, the Medical E	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11th	e completed) (Giv life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) ne Improvement	rking	(ind of Business/Industry If Employed
d 2 should be filed th and Mental Hygis 77 is marked other traumatic event.	17. Father's Name (First, Middle, Last) Charlie F. Smi	th	18. Mother's Nai	ne (First, Middle, Maider yn Edward:	S
permit. Pages 1 and 2 sho Department of Health and Importent: If tem 27 is m any injury or other trauma once.	19a. Informant's Name/Relationship (Ty Donna M. Smith 20a. Method of Disposition 1 Burial 2 Commation 3 F	- Wife 9403	ing Address (Street and Number or Richard Street and Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number	ST, Capite	ol Heights, MD ocation - City or Town, State
permit. P Departme Importen any injury	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	99		stin Roys	ter Funeral Hom
Physician /Medical Examiner	23a. Part 1. Enter the disease, or compl shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the death. No not elecable on each fine.	nter the mode of dying, such as cardial	Or respiratory arrest,	Approximate Interval Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	FIDRY FAIC	une-	
death certific e attending p d for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
es the igne be d	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
ician: The law requires that the certificate has been signed by the rector, page 2 should be detache. Be Completed by Phys				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 \(\text{Yes} \) 2 \(\text{No} \) No
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F 8 F C 12	3 Suicide 6 Could not be determined	28e. Place of fnjury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street and City or Town, State	nd Number or Rural Route Number, e)
n 24 hou n 24 hou he Funer pletely fill	29a. Certifier Certifying Physical Control (Check only one)	sicien: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	, and due to the cause(s) rred at the time, date and) and manner as stated. d place, and due to the cause(s)
To the To the Company of the Company	29b. Signature and title of certifier	echu	29c. License number	29d. Da	te signed (Month, Day, Year)
State Registrar	30. Name and address of person who con the control of the control	mpleted cause of death (Item 23a) (Type M. D	DH Mission H	III, Silver	Spring , MD

		-	For State	State of Mar	-	artment of F rtificate of				
			Registrar 1. Decedent's Name (First, Middle, Las	t)		Timeate of	Douth	2. Date of Death	3. No. 2 1 1 1	3. Time of Death
	Physicia /Medic	_	Raven	•	Summer	rs.		Month July 27	Day Year	4:40 P M
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Į,	Funeral Director		5/2-68-7540	ox □ M XXF / Age ((In yrs. last birthday) 59 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1	rear) CGP	hplace (State or Foreign unity) 110rnia
	and ww	1	Usuel Residence of Decedent 10a. State 10b. County	1	IOc. City, Town or Le	ocation				10d. Inside City Limits
	Maryl	to	Maryland Prince	George's	Waldorf					1 □ Yes 🔏 📆 💥 o
	th the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	eth wi	ral	16510 Bealle Hill			2060			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Madical Examinational Le notified all ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4√3 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 227No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
9	2 hou	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation	11	6b. Kind of Business/	
21215-0036	ithin 7 36.	Completed	(Specify only highest gra	College (1-4or 5+)	life.	kind of work done DO NOT use retired	d)	king		
7	lled w lygier ther th	Cor	17. Father's Name (First, Middle, Last)	5	Manag	ger / Co-(Owner	Bo ne (First, Middle, Mi	oarding Ke	nnel
and	id be i ental I ked o	To Be	Unknow	n			Unkno		aloen Somame)	
Maryland	s mar	-	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ing Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)
	and 2 lealth m 27 h		Helen Cordero/Per	sonal Rep.	4113	Offut Dr	ive Suit	land, Mar	yland 20	746
Baltimore,	ages 1 nt of F t: If ite		20a. Method of Disposition 1 ☐ Burial 2x☐Cremation 3 ☐			matory or other place	1		Oc. Location - City or	
Ħ	vartme ortani injury		*4 □ Donation 5 □ Other (Specification 21. Signature 5 □ Uneral Service Licen		Kalas Cr	2 Name and Addes	on of English	,	gewater,	
<u>ळ</u> —	Depa Impo any ii		Jar 6. Ka	las A	6	160 Oxon	Hill Roa	d Oxon Hi	Funeral H	and 20745
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the	ne death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Mal	gran	i Bra	in to	rows		mouth
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	ficate be executed physicien and s the buriat-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or se a	consequence of):					
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Вох	that the death certifi ed by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	□Ectopic pregnancy	,		23d. Date of del Month	ivery Day Year
o.	at the d by the stached	hysic	1 ☐ Yes 2 € No 9 ☐ Unknown	9□ Unknown						
s, P	Se un es	by P	Part II. Dther significant conditions of	ontributing to death but	not resulting in the	anderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord	w requir been si should							1 Tes	2 □ No 3 □ Pr	obably 4 Dunknown
Vital Record	0 - 9	Completed						24a. Was an autopsy perform	prior to	topsy findings available completion of cause of
a	icien: The l certificete ha rector, page	e Co	25. Was case referred to medical				00 81	1 ☐ Yes 2x	No 1 ☐ Yes	2 No
	S S	To B	examiner? 1 Yes 2 No	Hospital: 1 Anpatient	2 ER/Outpatie	nt 3□ DOA Oth	or	th <i>(Check only one</i> ome 5 ☐ Resider	/ ice 6 ∐Other <i>(Spe</i>	cifv)
n of			27. Manner of Death 1 → Natural 5 → Pending	28a. Date of Injury (Month, Day)		of 28c. Injur	y at	28d. Describe how		
isio	ten for: the	icati	2 Accident investigation 3 Suicide 6 Could not b		A hama farma		Yes 2 □ No	Opt Leasting (Cha		10
Division	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Diractor: completely filled in by the	Certification:	4 Homicide determined	building, etc.				City or Town,		
	Hosp 124 ho Fune letely fi	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	th occurred at the til nvestigation, in my o	me, date and place pinion, death occu	, and due to the cau rred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
17	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	, 00	,49 a (V.	29c. Licens	e number		d. Date signed (Monti	
			A. L. E	Helele	arri Ma	/	16046	pet	1-28.	2004
6			30. Name and address of person who Amir Mirza-Ali!				load Ft	Washingto	n, Marylan	nd 20744
	Sta Regist	ite	31. Date filed (Month, Day, Year) AUG 1 1 20	32. Registrar				- something co	,yal	10. 40/TT

			1 - State of Maryla		artment of H			ene	2521.0
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	S	chueler		2. Date of Death	Day Year 6 200	
)	Examin		4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital		4b. City, Town, or Baltimo		O Power (Pint)	4c. County of Dec	
	Funeral Director		5. Social Security Number 212 56 2900 1 □ M 2 □ XF 54 Usual Residence of Decedent	rs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y May 8, 1		rthplace (State or Foreign ountry)
	the Marylan 28a-f show offilled at	Director		City, Town or Lo			100	China d Mina C	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	23a or	al DIr	6474 Bricktown Circle		2106	51	100	U.S.	ounity ?
036	be filed within 72 hours after death with the Maryland ital Hyglene. ad other than "natural", or Items 23a or 28a-f show event, the Madical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	'	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2🌠 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W.	
21215-0036	I within 72 ho lene. r than "natu the Wadical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, Cretary	luring most of worki	ing 16	Bb. Kind of Business Medical	s/Industry
	0 = 0 %	Be	17. Father's Name (First, Middle, Last) Leo E. Williams, Sr.				(First, Middle, Ma	uth Weyri	c h
Maryland	2 should and Mer is mark aumatic	J.	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a	and Number or Rura	al Route Number, C	City or Town, State,	Zip Code)
	is 1 and 2 of Health a item 27 is other trac		Richard Schueler / husband 20a. Method of Disposition 20b	. Place of Dispo	Bricktown sition (Name of	! .		urnie, Ma c. Location - City o	ryland 21061 Town, State
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic angoes.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombment G 21. Signature of Fune al Strvice Licensee	len Hav	natory or other place ren Mem。 F 2. Name and Addres	Park 8/11,		len Burni ral Servi	
8	P P P P P		23a. Part1. Enter the disease of complications that caused the de		001 Ritch	ie Highwa	y Balt	imore, Ma	ryland 21225
78	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	`					Interval Between Onset and Death
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o o	cate be executed obysician and the burial-transit	Examiner	cause. Enter Underlying	liany c	irhosis				3 years
68760,	ficate be physici s the bu	edlcal	_ d.						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
۵.	w requires that the back of th	by	Part II. Other significant conditions contributing to death but not r	esulting in the ur	nderlying cause give	n in Part I.			o the cause of death?
Il Records,		Completed					24a. Was an autopsy performe	d? prior to death?	utopsy findings available completion of cause of
Vital	ysician: The is certificate hadirector, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	26. Place of Death		e 6 ⊟Other (Spe	acify)
Division of	ding Ph After th funeral	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work	at 2	28d. Describe how		,
Divis	al or Att s after de il Direct id in by t	Certifle	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	eet, factory, office	4	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my k 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tim vestigation, in my op	e, date and place, a sinion, death occurre	and due to the caus ed at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To t To t	Σ	29b. Signature empittle of certifier MD Residen	L	29c. License			Date signed (Mon	
	70		30. Name and address of person who completed cause of death (III TROY The John Hopkin Hope	т ет 23а) (Туре,	RES 600 N. W	olfe St.	Baltimen	MA	2004 21257
I	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2004 32. Registrar's Sig	nature	Sparks	/			~! · · · /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year **Physician** Spruill Jr 455 A M Jarrett Turner 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Mercy If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **1**2 M 2 □ F Director 10 MĎ 03 213-30-9153 Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Myulcal Examinar must be notified at 1 Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21215 5214 Linden Heights Ave Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Hospital Cook 9th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be file h and Mental H Be ٩ Lacie Ashe Jarrett T. Spruill Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Joyce M. Spruill-Wife 20a. Method of Disposition Baltimore, Md 21215 item 27 other to 5214 Linden Heights Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hr
Important: If iten
any injury or oth Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/14/04 Randallstown 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Litenses 4300 Wabash Ave, Baltimore, Md 21215 23a. P. rt1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician maloid lestremin aute /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. phys IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Wasan cate has page 2 s autopsy performed? Yes 2 \sum No 1 ☐ Yes Division of Vital Hospital or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) > 11 1 ☐ Yes 2 No P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification: Natural 5 Pending after death. investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MO D40854

State Registrar

AUG 1 1 2004

31. Date filed (Month, Day, Year)

David

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Riseberg

32. Registrar's Signature

301

St. Paul Pl.

2004

21202

MD

Bultmore

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear 2215 **Physician** 2004 Temple Henry /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Baltimore Union Mem. Hosp. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1√2 M 2 □ F Months Days Hours Min. Yrs. 218-18-6952 **Director** 3 - 10 - 24Md 80 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

ant: If item 27 is marked other than "neturel", or iteme 23s or 28s-f ehow ury or other traumatic event, if a Medical Examinational Les incitited at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Baltimore Be Completed by Funeral Director Md. NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21218 123 W. 29th Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎖 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ship Yard Laborer 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Huahes Bessie Temple, Sr. 2 Harvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5248 Daien Rd., Baltimore, Md. Sylvia Dyson Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State permit. Pege Department o Important: If eny Injury or once. 8-10-04 Arbutus, Md. *4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. lade A 1101 E. North Ave. March F.H. East Warre 23a. Part1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Seasis Physician day /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Month Dav Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 240 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) Hospital: 1 X Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA ပ this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1.XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of partifier 2438946E7 August 4 s of person who completed cause of death (Item 23a) (Type, Print) University Parkway Baltimore Mp 21218 201 Gressmen) 6 31. Date filed (Month, Day, Year) AUG 1 1 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 07 Wilkes August 2004 Martha 8:25p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Funeral Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 🗓 F Yrs. Director 243-40-7320 NC Usual Residence of Decedent with the Maryland 10a State 10h. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Exertities must be notified at Director XXYes 2 No MD Baltimore NΑ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 itams 23a 2902 Westwood 21216 Ave U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: þ Specify: **¾** Widowed 4 □ Divorced natural Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7: h and Mental Hygiene 7 is marked other than "n: Complet Coilege (1-4or 5+) Elementary/Secondary (0-12) N/A N/AHealth Care Center Nurses Assitance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Lizzie Ellis William Mercer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3528 Kentucky Ave. B Department of Health a important: if item 27 is any injury or other tre-Alexander Wilkes-Son Baltimore, Md 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State * 4 ☐ Ponation 5 ☐ Other (Specify) King Memorial Park 8/14/04 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 2 (2 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart of ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonico Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Alzheimer Disease Sequentially list conditions, if any, leading to immediate cause. First linderlying Cause (Disease or injury that initiated events Due to for as a consequence of). Examiner physician and the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 37 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No HOSPICE 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 7,2004 D0053275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice NGUYEN DONG 31. Date filed (Month, Day, Year) AUG 1 1 2004 32. Registrar's Signature State Registrar

Unpend item # 23a.27. per MR (835 9/9/04 TT

	ian	Decedent	s Name (First,		•	. To 55	7 -1-	1.7- 3.3-					2. Date of D	Da	, 2004 ^Y	/ear	3. Time of	
/Medi Exami		4a. Facility N	lame (If not ins		Majanae		zere	waday	•	, Town, or	Location	of Death	AUG.		. County of	Death	1220	I
Exami	ier	,	ERSITY							ALTIM					N/			
Funeral Director		213 (curity Number 67 6516		ex □M 2 X IF	7. Age (Ir 1	'n yrs. last	birthday) Yrs.	If Unde Months	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D Feb. 1	ay, Year)	003	Coun	ace (State of try) yland	r Fore
Mo 10		Usual Resid 10a. State	ence of Decede 10b. C			10	0c. City, T	own or Loc	cation							11	Od. Inside Ci	ty Lin
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or 28e	lrec	10e. Street a	and Number						10f. Zi	ip Code				10g. Cit	tizen of Wh	at Coun	try?	
23a	ai	219	Southe	rly Ro	oad					2122	25				U.S.			
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natur IIcali	eted		15. Dec	cedent's Ed	ucation	f)	1	6a. Deced	ent's Usu	ual Occupa	ation	et of worki	200	16b. K	and of Busi	ness/Inc	lustry	
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nd Me mark matic	P	19a. Inform	ant's Name/Rel					19b. Mailine	a Addres	ss (Street a	and Numb		I Route Numi			tate. Zio	Code)	
27 is	П		ty Monte			ther		219					Baltin					:5
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/Medical xaminer	al Examiner	disease or resulting in	Cause (Final condition death) r list conditions ng to immediate or Underlying asse or injury Levents	(a. Surg Due to		Repa:	ir of	и шу	hern		la Cu	прттса	LIIIg			Interval Bety	vee
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this certificate has been signed by the attending physician and relativisticate has been signed by the attending physician and relativisticate has been signed for use as the burial-transit	To Be Completed by Physician/Medical	disease or resulting in Sequentially if any, leading cause. Entropy is that initiated resulting in IF FEMALE 23b. Was do in the 1 Yes 9 Yes. 25. Was cause and the sequential Yes. 27. Wagner	Cause (Final condition death) I list conditions ag to immediate in underlying pase or injury levents death) Last eccedent pregnasst 12 months is 2 No niknown r significant co	ant?	a. Surg Due to b. Due to c. Due to d	o (or as a co	Repa: onsequent onsequent pregnancy Fetal de- ne of death	ir of ce of): ce of): ce of): function of the unit	Con	peri i	en in Part 26. Place	leart	23e. Did 1 24a. Wa auto	tobacco u Yes 2 s an ppsy omed? 2 \(\text{No} \) No one idence	23d. Date of Month	ute to th Proba	Fy Day Y Day Sy findings a poletion of car	/ear eath
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		-	State of Maryland / Department of Healt 1- State Registrar Certificate of Dea		ental Hygien	2001.	25253
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia /Medic		David Garfield Yontz		July 29	2004	9:13 А м
2	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Local		i	County of Deat	
_			Frederick Memorial Hospital Frederic 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Ur		8. Date of Birth	rederi	C K hplace (State or Foreign
Н	Funeral Director			ours Min	uly 9, 194	7 Co	Maryland
	D D		Usual Residence of Decedent				
	arylar show	_	Maryland Frederick 10c. City, Town or Location Jefferson	l			10d. Inside City Limits 1X☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Co	untry?
	3e or			1755		U.S.	Α.
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispania If Yes, specify Cuban, Me.	nic Origin? (Specexican, Puerto R	cify Yes or No-	14. Race - Ame Black, White	
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23e or 28e-f show event, I'm M. Jic.al Exactinat must be notified at	by Fu	1 Never Married 27 Married 17 Yes 2 No	ecify:		Specify: W	hite
8	tural		1975 15. Decedent's Education 1975		16b.	(ind of Business/	Industry
Maryland 21215-0036	within 72 ene. then "nat	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during life. DO NOT use retired)	g most of workin	1	.S. Post	al Service
2	e filed within al Hygiene. other then vent, Ine M.	Соп	5 Postmaster	AA-ab-ad-Alama			
and		Be			(First, Middle, Maide		
7	s 1 and 2 should be f Health and Mental itsm 27 is marked o other treumatic ev	ဥ	Harold Lee Yontz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No		yoda Ambre Route Number, City		Zip Code)
Z		r y	Vicki Scheib Yontz/Wife 4832 Champlaine	Drive,	Jefferson	n, MD 21	755
ore,	es 1 a of Hea fitam r othe		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place)	Da		ocation - City or	
Baltimore,	Pag ment tent: I		4 Donation 5 Other (Specify)	1	, 2004 F	rederick	, Maryland
Ball	permit. Pages 1 and Department of Health Importent: If itsm 23 any injury or other t		21. Signifure of Funeral Service Licensee MOOO21 22. Name and Address of Fixed Keeney and	Racford	Funeral	Home	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart failure. List only one cause on each line.	urch St	reet, Fred respiratory arrest,	derick,	Approxima e Interval Between
	Pnysician		shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition		./		Onset and Death
	/Medical		resulting in death) a Due to (or as a consequence of):	1-0	7.0		
П	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate Due to (or as a consequence of):	770	(7/	1-1)	400
	nted Insit	Examiner	Tany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
o,	an and rial-tra		resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcai	d				
9	eath certific attending p	0	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
Вох	death of attendation	Physician/M	23b. Was decedent pregnant in the past 12 months? 1			Month	Day Year
0	at the de by the	hysl	9 Unknown				
s, P	es tha igned be del	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in f	Part I.			o the cause of death?
ord	w require been sign	eted					
Records,	The law ate has b page 2 s	Completed		.	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
Vital		a	25. Was case referred to medical 26.	Place of Death	(Check only one)	lo 1 Yes	3
fVi	8 s = 0	To B	examiner?		ne 5 Residence	6 ☐Other (Spe	cify)
n of			27. Manner of Death 28a. Die of Injury 28b. Time of Injury at Work?		8d. Describe how in	ury occurred	
Division	Attending ir death. ector: After by the fune	icat	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		8f. Location (Street	and Number or R	ural Route Number.
Di√	of or Attence after death	Certification:	4 Homicide determined determined determined building, etc. (Specify)		City or Town, Sta		
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier (Check only (Ch	late and place, a	nd due to the cause	s) and manner a	s stated.
	the H hin 24 the F mplete	Medical	one) and manner stated.			ate signed (Mon	
	Wil To	-	200. Olginatura di la				
1			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6 76	70	0/	701
10			JG 1210305 NA 501 NA 153	51-	F-ed	1-10	MO
		ate	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 1 1 2004 August 1 2004	2			
	Regist	rar	MAGIT T SOOK A LONG TO LANGE T	_			

20c. Location - City or Town, State

r then "natural", or items 23a or 28e-f show If a Medical Exercit at must be notified at Baltimore, Maryland 21215-0036 7 Is marked other traumatic event, I permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other trau once.

Physician

/Medical

Examiner

Director

Funerai

δ

Completed

Be

20a. Method of Disposition

Vidyasagar 31. Date filed (Month, Day, Year)

1 2004

1

Burial 2 □ Cremation 3 □ Removal from State

10a. State

Funeral

Director

Physician /Medical **Examiner**

ng physicien and as the burial-transit attending for use as ned by the a certificate has birector, page 2 s After this To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

Division of Vital Records, P.O. Box 68760

	21. Signature of Funeral Service License	° M00479	22. Name and A RAYMON	CTERY AUGU	SERVICE	, P.A.	ONT, MD.							
П	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.			AND 2004 or respiratory arrest,	6	Approximate Interval Between Onset and Death							
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	EUMO	NIA										
miner	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	∍ of):											
ical Exar	that initiated events c. resulting in death) Last													
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 Ectopic pregr			23d. Date of de Month	livery Day Year							
d by Ph	Part II. Other significant conditions conf	tributing to death but not resulting	in the underlying caus	e given in Part I.	23e. Did tobacco		the cause of death?							
complete	HYPERT ATHERO-SC	LERDTIC	HEART	DISEASE	24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of the caus							
BeC	25. Was case referred to medical		1,0-11-		h (Check only one)									
To B	examiner?	ospital: 1 Inpatient 2 ER/0	Outpatient 3 DOA	Other: 4 Nursing Ho	me 5 Residence	6 ☐Other (Spe	icify)							
ation; 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 2												
Medical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, o	fice	28f. Location (Street City or Town, Sta	and Number or Ri ate)	ural Route Number,							
edical (29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due to the cause(s) and manner at the time, date and place, and due and manner stated.													
ž	29b. Signature and title of certifer	lla	29c. L	cense number	29d. D	Date signed (Mont	th, Day, Year)							
	Do Name and address of passen who so	and I		D-26064		7-30	-2004							

Anmangandla MD PO Box 282 Charlotte Hall, MD 20622

parks

20b. Place of Disposition (Name of cemetery, crematory or other place)

DHMH 17 Rev 1/2001

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 29 2004 **Physician** 2:30P M JAMES DAVID ADKINS /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES WELCOME 6650 DUPLESSIS PLACE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months | Days | Hours | Min. | SEPT • 18,1944 | KANSAS 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□ F 59 Yrs. 428-82-9093 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23s or 28s-f show the Medical Exemples must be notified at 1 ☐ Yes 27 No Director WELCOME MARYLAND CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20693 6650 DUPLESSIS PLACE U.S.A. Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHTTE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. om 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) U.S.NAVY DEPT. 12 5+ CHEMIST traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ARCHIE ADKINS ELEANOR LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health as Important: If Item 27 is any injury or other trau 2005. 6650 DUPLESSIS PL. WELCOME, MARYLAND 20693 DIANE M.ADKINS-SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) M.F. METROPOLITAN CREMATORY 7-31-04 ALEXANDRIA, VIRGINIA Page 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P. A.
LA PLATA, MARYLAND 20646 21. Signature of Funeral Service Licensee MQ0479 6 Micho 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and I-transit The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Physician/Medical as the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) \(2 \text{\subset} \) No page 2 s certificate 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 A esidence 6 Other (Specify)
Injury at 28d. Test ibe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day Year) 27. Manner of Jeath 28b. Time of 28c. Injury at Work? Certification: After or Attending 1 Natural 2 Accident 5 Pending Injury hours after death. uneral Director: Aft sky filled in by the fun 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person w leted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 1 1 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland		artment of rtificate of		_	iene •9. N2 () () ()	25256
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Joseph Souto Amac	lo, Jr.		45 Cib. T		2. Date of Deat Month July 25	Day Year 2004	3. Time of Death
	Examin	ier	4a. Facility Name (If not institution, give : 8744 Valley Drive	street and number)		Waldor	or Location of Dea f	:n	4c. County of Dea Charles	tn
F	uneral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs		9 Rir	thplace (State or Foreign buntry)
	irector		129-26-0127 Usual Residence of Decedent	70	Yrs.			Nov. 17,	1933 New	ı York
iryland	thow		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits 1 Yes 2 No
the Ma	28a-f s	ecto	Maryland Charles 10e. Street and Number	Wa	1dorf	10f. Zip Code		71	0g. Citizen of What Co	
with	3a or	I Dir	8744 Valley Drive			2060			Jnited Stat	•
1215-0036 within 72 hours after death with the Maryland	Department of results and wender rygiene. Important: If there 27 is marked other than "natural; or thems 23a or 28a-f show Important: If the 27 is marked other than "natural; or them 27 is marked other than "notice. DDCs.	by Funeral Director		12. Was Decedent Ever in U.S Armed Forces? 1 M Yes 2 ☐ No If Yes, Give Year or Dates:	- 1		Hispanic Origin? (Suban, Mexican, Puer		14. Race - Ame Black, White Specify:	encan Indian,
5-0 72 ho	natura dical E	eted	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occ	e during most of wo	rking	16b. Kind of Business	
Maryland 21215-0036 nd 2 should be filed within 72 hours af	than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retil rintende		N	Metro Trans	it System
id 2	other than	Be Co	17. Father's Name (First, Middle, Last)		Super	THECHAC		me (First, Middle, M		31 t
aryland should be f	Menta arked atic a	To E	Joseph Souto Amad					nche Alle		
Mar d 2 sh	27 Is m	/ 8	19a. Informant's Name/Relationship (Ty Clarice Amado-wif			•	_{et and Number or R} Drive, Wa		City or Town, State, .	Zip Code)
re, N s 1 and	item 2 other		20a. Method of Disposition	20b. Pf	ace of Dispo	osition (Name of matory or other p			20c. Location - City or	Town, State
Page	ant: #		1 🖾 Burial 2 □ Cremation 3 □ P 1 □ Donation 5 □ Other (Specify)	emoval from State	•			29-2004	Clinton, Ma	ryland
Baltimore, permit. Pages 1 an	Import any inj once.		21. Signature of Funeral Service Licens	™ M01246		2. Name and Add ntt Fune				
	ysician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	cations that caused the death ne cause on each line.	. Do not ent	ter the mode of d	eral Home 156 Waldon ying, such as cardia	c or respiratory arre	604-0156 est,	Approximate Interval Between Onset and Death
/M	ledical		disease or condition resulting in death)	Due to (or as a consequ		<i></i>		-		
EX	aminer	_		Due to (or as a contage	sar eo alla					
petr	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	See to (St de d'outleade	or ned Ory.					
760, te be executed	hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a consequ	ience of):					
	ohysici the bu	dlcal		J						
. Box 68	attending phy I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar				-	23d. Date of de	livery
	the atter	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetat 4 ☐ Pregnant at time of de 9 ☐ Unknown		□Ectopic pregnar □ Other (specify)			Month	Day Year
Records, P.O.	a o	Phys	9 ☐ Unknown Part II. Other significant conditions con		ulting in the u	inderlying cause (niven in Part I	23e. Did tot	pacco use contribute to	the cause of death?
ds,	5 8		Takin one organization of			g oacco	g			robably 4 Unknown
Vital Record sician: The law requir	s been si 2 should (Completed						24a. Was a		utopsy findings available completion of cause of
	cate has	Com						perform	ned? death?	
Vita	certifi	Be	25. Was case referred to medical examiner?	lospital:			*than	ath Check only on		
of Phys	두 교	n: To	27. Manner of Dea	28a. Date of Injury	ER/Outpatier 28b. Time o	f 28c. In	ury at		ence 6 Other (Spe ow injury occurred	cify)
ion	or: After	atlo	Pending 2 □ Accident 5 □ Pending investigation	(Month, Day Year)	Injury		lork? □Yes 2□No			
Division of Attending	Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, offic	60	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
Hospita A bours	within 24 hours after deals To the Funeral Diractor: completely filled in by the	edical C	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exami	siciam: To the best of my know ner: On the basis of examinat and manner stated.	mouge, deat ion and/or in	h occurred at the evestigation, in my	time, date and plac y opinion, death occ	e, and due to the di urred at the time, di	ate and place, and due	stated, a to the cause(s)
To the	To the complet	Me	29b. Signature and title of certifier	111.07		29c. Lice	nse number	2	9d. Date signed (Mont	h, Day, Year)
7		5	Hour!	March		103	+ + 3	1	1140/0	4
MP.	201		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Plak	1	el d	-0646	
	Sta Regist		31. Date filed (Month, Day, Year) JUL 2 8	32. Registrar's Signat	ture	books				

		4	For State Registrar	State of Mary		artment of H tificate of L			ene . No 2001	25257
F	SEL		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yee	3. Time of Death
	Physicia /Medic		Mabel Anna	Arnold					6 200	
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or	Location of Death		4c. County of De	eth
	>		Frostburg Village Nu			// N	Frostburg		Allego	
	Funeral		5. Social Security Number 6. Sex 1 - 07-4033	M 0575	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		irthplace (State or Foreign Country)
X.	Director	-	Usual Residence of Decedent	M 290 F 9	115.			14-0ct	-1912	Maryland
	and and	1	10a. State 10b. County	100	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary	Ö	Maryland Alleg	any	Frostburg					1 X Yes 2 □ No
	the 28a	Director		Wencks Lane		10f. Zip Code		100	. Citizen of What	Country?
	3a of	<u>=</u>	17101	World Edito		21532	-		U.S.A.	
	death ms 2	Funeral	11. Marital Status	2. Was Decedent Ever	in U.S. 13. \	Vas Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	nencan Indian,
o	after or its	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	i	Tes, specify Cuba	Specify:	nican, etc.)	Specify:	nite, etc.
0500-c	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23e or 28e-f show ther than Medical Examiner must be routilised at	d by	3 Widowed 4 □ Divorced	Year or Dates:		2.00 92.00			Specify.	White
h	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occupa kind of work done of	turing most of worki	ing 16	b. Kind of Busines	ss/Industry
V	vithin ne. han	dE	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired memaker)		homemak	0.4
V	liled v lygie ther t		17. Father's Name (First, Middle, Last)	<u> </u>	110	memaker	18. Mother's Name	(First Middle Ma		el
and	ad of	Be	Daniel Clark				Minnie		idan osmano,	
Ē	should nd Men marka umatic	၉	19a. Informant's Name/Relationship (Typ	e Print)	19b. Mailin	ng Address (Street a	and Number or Rura		City or Town. State	Zin Code)
<u> </u>	and 2 s ealth an n 27 is		Eileen McFarland	Daughte	92	West College	AVENUE	ostburg	Maryl	
อ์	Hea tem other	18	20a. Method of Disposition	2	Ob. Place of Dispo				c. Location - City	
altimor	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Finzel Cem	natory or other plac etery		09-Jul-2004	Finzel	Maryland
	그 돈 말 금	1	21. Signature of Funeral Service License		22	. Name and Addres	s of Facility			
מ	Department Department Important ir any ir gonce.		John K.	Cury		Durst Funer	al Home, 57	Frost Ave.,	Frostburg, I	MD 21532
۲			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that ceused the			-		1,	Approximate Interval Between
Ų.	Physician		Immediate Cause (Final disease or condition		DEN	CARDI.	AC DE	ATH		Onset and Death
	/Medical		resulting in death)	Due to (or as a co	nsequence of):	1.0	~ .	1)1.1		0.12
	Examiner		Sequentially list conditions b.	Co	RUN ARY	184	ERY DIS	EASE		about 104M
	D :=	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):		,			
	and -trans	Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
2/00,	certificate be executed iding physicien and ise as the burial-transit	icai E		Due to (or as a co	nisoquentoe orj.					
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2	death e atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time]Ectopic pregnancy] Other (specify)			Month	Day Year
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cords,	w require been signated should to	ed	DIABETIES	MELLITY	is Al	WITH MIS	MATH	1 ☐ Yes	2 □ No 3 □	Probably 4 DUnknown
ပ္သ	law as b 2 sl	pleted	CONGRESTIVE	HEART F	MLURE			24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
	The ate h page	Com						performe 1 ☐ Yes 2 ☑	d? death	?
VII all II	Physicien: r this certific ral director,	Be (25. Was case referred to medical examiner?				Tark to the second seco	(Check only one)		
5	Physic this o	ပ္	1 ☐ Yes 2 DNo	spital:	2 ER/Outpatien		Pr: 4 Nursing Ho			pecify)
	After uner	0	27. Manner of De th 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time of Injury	Work	/at ⟨? Yes 2 ∐No	28d. Describe how	injury occurred	
VISION	Attending r death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home form etc			28f Location (Stre	et and Number or	Rural Route Number.
2	after Direct in by	ertification;	4 Homicide determined	building, etc. (S	pecify)	eet, lactory, oillos		City or Town,		Tarar Flobio Fibrilipes,
_	spital ours neral filled	OI	29a. Certifier 1 Certifying Phys	cian: To the best of m	y knowledge, death	occurred at the tim	ne, date and place,	and due to the cau	se(s) and manner	as stated.
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edicai	(Check only 2 Medical Examin one)	 er: On the basis of exa and manner stated. 	mination and/or in	vestigation, in my or	pinion, death occurr	ed at the time, date	and place, and d	ue to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier			29c. License		290	. Date signed (Mo	nth, Day, Year)
	3) Its	rettr		1269	707	J	4246,	2004
	YN AS		30. Name and address of person who cor		(Item 23a) (Type,	Print) /	2.1.1 n	2 1	10	MD 2/502
	7.		Harjit Sidh 31. Date filed (Month, Day, Year)	M.P. 32. Registrar's	723 /3	sishop h	raish Kd	Lumb	eriand,	11/1/2/502
	Sta	te ar	JUL 0 7 2004	1 -	a L	1 ,				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** David Michael Bennett 22, Ju₁y 2004 12:43 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 320-32-0751 1 M 2 □ F 67 Yrs. Director July 17, 1937 England Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. In: If Item 27 is marked other than "naturel; or Iteme 23s or 28e-1 show 10c. City, Town or Location Rockville 10a. State 10b. County 10d. Inside City Limits rel', or iteme 23a or 28e-f show Examiner must be notified at Maryland Montgomery 1 Yes 2 □ No Funeral Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20851 605 Linthicum Street United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed by 3 ☐ Widowed 4 X Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Wireless/Satellite Elementary/Secondary (0-12) College (1-4or 5+) Technology Contract Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dorothy (Unknown) Eric Michael Bennett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Importent: If Item 27 is any injury or other treu once. Michael Bennet / Son 12320 Piedmont Rd., Clarksburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery | 07/27/2004 | Frederick, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service L 22. Name and Address of Facility Olin L. Molesworth, P.A. Funeral Home 26401 Ridge Road, Damascus, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Acute Myocardial Infarction 2hours /Medical Due to (or as a consequence of Examiner Caronary Artery Disease sequentially let considers, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 7 1 Inpatient 2 ER/Outpatient 3 DOA this After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 | Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 041311 July 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6410 Rockledge Dr. #200, Bethesda, MD Yuri A. Deychak, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 boards! Registrar

Lawrence D. Brock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 5001Unpend Item #23a,2/,28a-f per me G834 8/1//04 tas AKG Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 2004 **Physician** Lawrence D. Brock August 1, 4:05 P M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 12014 Lilium Lane Glenn Dale Months Days Hours Min. June 119, Year) 6. Sex 1 → M 2 → F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Wash., DC 47 Director 579-76-1426 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28a-f show rel', or Items 23e or 28a-f shov Examiner must be notified at 1 ₹ Yes 2 No Directo Glenn Dale Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12014 Lilium Lane 20769 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etcan filed within 72 hours after 1 □ Yes 2 Z No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates: 'neturel'. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Madical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iene. College (1-4or 5+) Elementary/Secondary (0-12) Security Officer Private Pages 1 and 2 should be filed w treent of Health and Mental Hygier tent: If item 27 Is marked other th jury or other traumatic event, IL. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Betty Minton Lawrence Brock 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12014 Lilium Lane, Glenn Dale, MD Keith Brock - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Lincoln Memorial Cem. 8/6/2004 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses war 4001 Benning Rd., N.E. Wash., DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Narcotic Intoxication(Morphine and Codeine) disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1X Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) at Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 ☐ No 2 this 28a. Date of Injury **Found**, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Certification: To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After 1 Natural 5 Pending investigation Found 1 Yes 2 No 2 Accident 8/1/2004 3:57 6 Could not be 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and 17014 Russ Flate Number City or Town, State) 4 Homicide Found at residence Glenn Dale, Maryland 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 2, 2004 O.C.M.E. Yamen. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Southail, MQ Pamela E.

Registrar

State

1. Date filed (Month Day.)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Catherine Lillian Conrad July 29,2004 /Medical 3:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Williamsport <u>Homewood at Williamsport</u> Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F Director 214-09-2437 90 December 16,1913 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Items 23a or 28e-f show 10d. Inside City Limits the Medical Evandriar must be notified a Williamsport Director Maryland Washington 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Avenue 21795 U.S.A. filed within 72 hours after death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 X Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 4 Homemaker other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other traumatic avent Be 18. Mother's Name (First, Middle, Maiden Sumame) Henry Wagner 2 Henrietta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine C. Keagle Granddaughter 9303 Mist Haven Court, Ellicott City, Md. 21042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematorium 08-31-04 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ቾሰህቸውው Kdਾ≎SCoff™an Funeral Home, Inc. K. Roel D 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate A terval Between Ot set an Leath Immediate Cause (Final disease or condition resulting in death) **Physician** PTICEMI /Medical as a consequence of): Laun trmaning **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of), P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy page certificate Vital 1 ☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this Division of 27. Magner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After s after de. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signat 29c. Lisense number 29d. Dafe signed (Month, Day, Year) DICIA 14 eta 30 Name pleted cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 1 2004

ather ine

			For State Registrar		State of M	aryland	-		of Health a	ind Menta	al Hygie	2001	25261
			Decedent's Name	e (First, Middle, L	ast)						te of Death	5	3. Time of Death
	Physici /Medi			IDA	JEAN	C	HRIST	ľY			tua us	03200	4 3 %
•	Examir		Man	shin.	ive street and number	(Priv	vn, or Location o	Ann	2	4c. County of Dea	erse+
	Funeral Director		5. Social Security N 216-18-8		.Sex 7.A 1 ☐ M 2 ☑ F	ge (In yrs. la 80	st birthday) Yrs.	Months D	ear If Under 2 ays Hours	Min. 8. Da	te of Birth onth, Day, Ye ber 19,	9. Bin (Co 1023 Ma	thplece (State or Foreign country) arvland
			Usual Residence of			- 00				<u>uu</u>	DEL 197	1922 Ma	Lytand
	nylan Mow		10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
	8a-f	Directo	Delaware	Sus	sex	1			urel				1∑ Yes 2 No
	th of		10e. Street and Nur					10f. Zip Co			10g.	Citizen of What Co	untry?
	eath y	era	RR4 BOX	502	12 Was Decedent	Ever in U.S.	13 W	/as Decedent	19956	in? (Specify V	e or No	USA 14. Race - Ame	erican Indian
	laryiand 21215-0036 2 should be filad within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "naturel", or Iteme 23e or 28e-1 show eumatic event, the Madical Examinar must be notified at	by Funeral		ied 2 Married	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	No	1	Yes, specify	of Hispanic Orig Cuban, Mexican, No Specify:	Puerto Rican,	etc.)	Black, Whit	
5	72 ho	Completed	/Snec	15. Decedent's	Education grade completed)		16a. Deced	ent's Usual O	ccupation	of working	16b	. Kind of Business	Industry
王		ם	Elementary/Seco		College (1-4or	5+)			lone during most etired)	o. noming			
· = 1	N post	S	17. Father's Name		et)		Care	egiver	18 Mother	r's Name (First,		ne Health	Care
Hrish	Maryland d 2 should be flis th and Mantal Hy 77 Is marked oth treumatic event	Be			31,							on Sumame,	
0	Should Ma	၉	Milton C		(Type, Print)		19b. Mailing	Address (St		oy Head] r or Rural Route	_	ty or Town, State, 2	Zip Code)
	2 75 5		Angela H	I. Bunne	r (Daughte:	c)						aware 199	
0	of Hard		20a. Method of Disp				ce of Dispos	ition (Name of atory or other	of place)	Date	20c.	Location - City or	Town, State
13	attimore mil. Pages 1 appartment of Ha portant: If Item y injury or oth			5 ☐ Other (Spec	☐Removal from State cify)			Cremat		uq. 5,	2004	Salisbur	y, Maryland
DA Jean	Baltimore, parmit. Pages 1 and Dapartment of Healt Important: If Item 2 eny Injury or other page.		21. Signature of Fu	Rockins	ensee Modsfow- adshaw-Pruj	Puill	1		ddress of Eacility	'Funera	1 Home		land 21817
(2)					mplications that cause ly one cause on each							9	Approximate Interval Between
	Friysician		Immediate Cause (Final	10	none	Ui	1 22 4	reart	5 . 4 7	-	Leve Fre	Onset and Death
	/Medical Examiner		resulting in death)	- 1	Due to (or as	a conseque	ence of):	1					
	Examiner	<u>.</u>	Sequentially list con	nditions,	b Due to (or as	2 CODE 0 0 116	ance off:						
a	ted nsit	틑	Sequentially list confiant, leading to imcause. Enter Under Cause (Disease or	rhying {	000 10 (01 22	a conseque	siles oi).						
1	B / DU, sata ba axacuted hysician and the burial-transit	Examiner	that initiated events resulting in death) I		c. Due to (or as	a conseque	ence of):						
V 8	6 / OU ata ba a hysician tha buri	lcal			d	<u>.</u>							
	o ph as th	Jed	IF FFEMALE.	1									
	tandir or usa	and	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outcome 1 Live birth			Ectopic pregn	ancy			23d. Date of del	ivery Day Year
	UNISION OF VITAL RECORDS, P.O. BOX 68/60, f or Attending Physician: The law requires that the death cartificate be executed after death. Director: After this cartificate has been signed by the attending physician and in by the funeral director, page 2 should be deteched for use as the burial-transi	Physician/Med	1 Yes 25 9 Unknown	Z'No	4☐Pregnant a 9☐Unknown	t time of dea	ıth 5□	Other (specify	y)			MORIT	Day 19ai
•	ulras that signad b d ba data	by Pt	Part II. Other signif	icant conditions	contributing to death I	out not result	ting in the un	derlying cause	e given in Part I.	23	e. Did tobacc	o use contribute to	the cause of death?
	COLOS w raquira baan sig should b	8	Inne	uns	nea						1 🗌 Yes	2∭2No 3∏Pr	obably 4 □Unknown
	as been 2 should	Completed	Den	nent	lie					24	a. Was an autopsy	24b. Were au	topsy findings available
	Tha Tha ata he	Ĕ								10	performed Yes 2 2		completion of cause of
	Ita clan: artific totor,	Be	25. Was case reference examiner?	red to medical						of Death (Chec	k only one)		
	ohysic this c	၉	1 ☐ Yes 2 🛣		Hospital: 1 ☐ Inpati		R/Outpatient					6 ☐Other (Spec	ify)
	SION OF VICAL MEGINE The lavitable. The lavitable. After this cartificate has the funeral director, page 2	<u>e</u>	27. Manner of Deating 1 Natural	5 Pending	28a. Date of Inj (Month, Da	ly Year)	8b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ N	7-	scribe how in	ijury occurred	
	JVISIO	Cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be One Diese of le	iury - At hom	ne farm stre				ation (Street	and Number or Ru	ural Route Number
Ž	affor din bi	Certification;	4 Homicide	determine	building, e	ic. (Specify)		0., 140.01,		Cit	y or Town, St	ate)	
	DIVI	ledica C	29a. Certifier (Check only one)	t⊠ Certifying F 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination	ledge, death on and/or inve	occurred at the estigation, in r	ne time, date and my opinion, deati	place, and due h occurred at th	to the cause e time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th To th compl	₩ M	29b. Signature and	title of certifier	7	, (29c. Lic	cense number		29d. [Date signed (Month	n, Day, Year)
			Tres	enall	15ella	and the	-	D	2950	5-	0	8-04	-04
	-74		20. Name and addre	ess of person wh	o completed cause of	death (Item 2	23a) (Type, F						
	1		GREGOR		ELLOSO,			CHINA	BERRY I	PR. SA	Lisen	RY MD	21801
	Sta Registi		31. Date filed (Mon	th, Day, Year)	32. Regist	rar's Signatu	re						
	DHMH 17 Rev 1/2		A	UG 1 1 2	2004 5.	C. Comband	6	door	Kal				
	1104 1/2		-		/		/	/ /	-				

ORIGINAL

		•	- State Registrar AMEND ITEM	26 PER VERB	G834C 8 4	Michola of	Death		Reg. No.	001	25262
	Physici	an	1. Decedent's Name (First, Middle, Last) Reeco	Senjamin	C	lark		2. Date of De Month	Day	O 4	S. Time of Death A
<u>)</u>	/Medic Examin		4e. Facility Name (If not institution, give s			4b. Cily, Town, o	r Location of De	eeth	4c. C	ounty of Death	
	E Addition		8101 Eastern Av	eņue			er Sp			ntgome	
	Funeral Director		5. Social Security Number 6. Sex 1534 - 48 - 5725	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bin (Month, Date of Bin)	th i <i>y, Yeer)</i> - 5.5	9. Birth Cou	plece (Stete or Foreign ntry)
•	Ö		Usual Residence of Decedent					J_22			
	arylar show	_	10a. State 10b. County		City, Town or Lo	ation Leasant					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	28e-f	Director	MD P.G.		beat I	10f. Zip Code			10a Citiza	on of What Cou	
	a or		6904 Seat Plea	sant Dr #	103	2074	3		rog. Ones	U.S.	, .
	neath	Funeral		12. Was Decedent Ever in	U.S. 13. V	Vas Decedent of H	lispanic Origin?	(Specify Yes or No	p- 14	. Race - Amen	
220	n 72 hours after death with the Maryland "natural", or items 23a or 28e-f show adical Examinatinasi be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yas, Give	982/	Yes, specify Cub. ☐ Yes 2 No	Specify:	reno Hican, etc.)	S	Black, White SpecifyBla	
	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade		(Give	ent's Usual Occup kind of work done	during most of	working	16b. Kind	d of Business/Ir	ndustry
9500-61212	- 3	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	olisher	d)		Gov	vernme	nt
	illed within Hygiene other than		17. Father's Name (First, Middle, Last)	4			18. Mother's	Name (First, Middle	, Maiden S	umame)	
Viari		To Be	Walter Large					Belle			
ž	and and		19a. Informant's Name/Relationship (Ty) Nikita A. Brown			,		ds. Dr.			
40)	of Health item 27 other tr		20a. Method of Disposition		. Place of Dispo	natory or other pla	ce)	Date		ation - City or T	
altimore,	nit. Page artment o ortant: If injury or e.		Wall Burial 2 ☐ Cremation 3 ☐ R * 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Ma	aryland Chelt	d Veter	ans 7_	16-04	Che	ltenha	m, MD
Dall	permit. Pages Department of the Important: If ite ony injury or of once.		21. Signature of Funeral Service License	C 1200:	222 Be	. Name and Addre		oc. Fun			Inc
4			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the de	eath. Do not ent	or the mode of dyi	ng, such as care	diac or respiratory a	rrest,	20010	Approximate Interval Between
<u>)</u> [hysician		Immediate Cause (Final disease or condition	Cardiov	asc V	ar V	nears	0			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons							mi
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):	02					
	cate be executed obysician and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	naveneo of						
8/60,	be ex sician burial	al E		Due to (or as a cons	aquatica oi).						
00	ificate g phys	edical									
ŏ	leath certifi attending f for use as	M/u	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pred 1 □ Live birth 2 □ Fe		Ectopic pregnanc	v		23	d. Date of dein	
j j	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time o		Other (specify)	,			Month	Day Year
J.	res that the de igned by the a be detached i	by Ph	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
Sol	w requires been sig should be							_ 10	Yes 2	No 3 Pro	bably 4. Unknown
Records,	elawre hasbee je 2 sho	Completed						24a. Was		24b. Were aut prior to co	opsy findings available ompletion of cause of
		Som						perf 1 ☐ Yes	ormed? 2 X No	death?	_
Vital	Physician: Th this centificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		0#	ner	Death (Check only		0.51.6	MOTHER"S
0	Phys this ral dii	2	1 XYes 2 No 27. Manner of Death	1 ☐ Inpatient 2 28a. Date of Injury	ER/Outpatier	t 3LI DOA	4 Nursir	ng Home 522 Res 28d. Describe	how injury	ther (Spec	residence
	Attending I r death. ector: After by the funer	tlon	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)) Injury	Wo	rk?]Yes 2 □ No		,		
DIVISION		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe		eet, factory, office			(Street and wn, State)	Number or Rui	al Route Number,
ב	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 ☐ Certifying Phys	sician: To the best of my k	cnowledge deat	occurred at the t	me. date and p	lace, and due to the	cause(s) a	and manner as	stated.
	To the Hospite within 24 hours To the Funerel completely filled	Medical		ner: On the basis of exam- and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen			29d. Date	signed (Month	
			トチョング	ckern	omi	100	0428		JU	14 13	15004
		1	30. Name and address of person who co	ompleted cause of death (I	tom 23a) (Type	Dun 2 101	MAN	ical F	211	1)1	
			IRA N BRECI	WER MO D	me	Silve	S. C.	icax)	no	2	0 9

			1 - For State Registrar	State of Ma	aryland / Der <i>Ce</i>	partment of H Prtificate of L			iene •g. No.2 () () ()	25263
	Physici	an	Decedent's Name (First, Middle, TITIOMA C. TARL CO.T.					2. Date of Death Month	Day Yeer	
100	/Medic Examir		THOMAS EARL COLI			4b. City, Town, or	Location of Death	JULY	19, 200 4c. County of Dec	
	Consul		311 DEREK STREET 5. Social Security Number 6		je (In yrs. last birthda	-	R MARLBO			GEORGES
	Funeral Director		439 68 3129	XXM 2□F	57 Yrs.	Months Days	Hours Min.	Month, Day, DEC. 03,	Year) C	rthplace (State or Foreign ountry) UISIANA
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	he Mar 8a-f et	Director		GEORGES	UPPER MAR					XX Yes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow rmust be ricilitied at		10e. Street and Number 311 DEREK STREET			10f. Zip Code	0774	10	0g. Citizen of What C $UNITED$,
	tems 2	Funeral	11. Marital Status	12. Was Decedent Адреd Forces?	Ever in U.S. 13	. Was Decedent of Hi If Yes, specify Cubar		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	encan Indian,
920	be filed within 72 hours after death with the Manylan tal Hyglene. d other then "natural", or lems 23s or 28s-f ehow event, the Mudical Exactiner must be recitled at	by	1 ☐ Never Married ŽŽ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? Armed Forces? Armed Forces? If Yes, Give Year or Dates:	№ 1965 - 1967	1 □ Yes XX No	Specify:		Specify: BL	
21215-0036	"natur	Completed	15. Decedent's (Specify only highest)	Education grade completed)	16a. Dec	edent's Usual Occupa e kind of work done d	luring most of wor	king	16b. Kind of Business	/Industry
212	d withir glene. or then	ошо	Elementary/Secondary (0-12)	College (1-4or 5	5+) /ife.	SPECIAL (U.S. SECR	ET SERVICE
and	be filed ntal Hygi ad other event,	Be	17. Father's Name (First, Middle, La				18. Mother's Nam	ne (First, Middle, M		
Maryland	should be ind Menta marked umatic ev	To	LEEVESTER COLE 19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Street a		HOLMES	City or Town, State,	Zip Code)
	s 1 and 2 f Health a item 27 le		ERMA COLE / WIFE	3	311	DEREK ST.	UPPI	ER MARLBO	ORO, MD 20	774
TOL	m O		20a. Method of Disposition XX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe			osition (Name of ematory or other place	ı		20c. Location - City or	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service-Lice	ensee)	GARDEN O		7–26 s of Eacility FUNERAL		ZWOLLE, 1	
1/5	40 F # 9		23a. Part1. In er the disease, or co	mplications that caused	4	308 SUITLA	AND ROAD	SUITA	LND, MD 20	0746 Approximate
	Physician		shock, or heart failure. List on Immediate Gause (Final disease or condition	ly one cause on each lin	N 0	Shuce	C: LAA		0	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a. Due to (or as	a consequence of):	111	SWY	a en		
0		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Que to (or as	a consequence of):	illu.	12 be	11-	3 1	
	ificate be executed g physician and as the burial-transit	Examlne	Cause (Disease or injury that initiated events resulting in death) Last	· Hup	ertena a consequence of):	unp Ca	sus	vasu	las des	Pap
6876 0,	ysician ysician e buria	edical E		d	a consequence or).					
_	E 00 %		IF FEMALE:	00 11						
XO RO	death certif e attending id for use a	Iclan/M	23b. Was decedent pregnant in the past 12 months?	4☐Pregnant at	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
J.	d by the	Physi	9 Unknown	9□ Unknown						
g,	w requires that the death cer been signed by the attendin should be detached for use	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause give	n in Part I.		acco use contribute to s 2 NNo 3 □ Pr	o the cause of death?
ecord	law rec as been 2 shou	ompleted						24a. Was an autopsy	24b. Were au	itopsy findings available
<u>r</u>	n: The icate h r. page	O						perform 1 Tes XX		completion of cause of 2 No
rvitai	nysician iis certit directo	To Be	25. Was case referred to medical examiner? XXYes 2 □ No	Hospital:	nt 2 ER/Outpatie	00		th <i>(Check only one</i>	nce 6 Other (Spe	cify)
on or	ling Ph After th funeral		27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time (Work'	at ?	28d. Describe how		Only
DIVISION	Attend r death ector: by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inju	ury - At home, farm, si		es 2 No	28f. Location (Stre	set and Number or Ru	ural Route Number.
5	urs afte			building, etc				City or Town,	State)	
	To the Hospitel or Attending Physician: The law within 24 hours after deadle. To the Funeral Director, Aller this certificate has completely filled in by the funeral director, page 2 s.	edical	29a. Certifier XXX Certifying I	Physician: To the best of aminer: On the basis of and manner sta	examination and/or if	th occurred at the time nvestigation, in my opi	e, date and place, inion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	Within To the comp	×	29b. Signature and title of certifler	Maria	M ()	29c. License	number	290	d. Date signed (Monti	h, Day, Year)
^	a A ill		30. Name and address of person wh	opcompleted cause of de	eath (Item,23a) (Type	Print) D	1625	124	TIVIC	14
1	- (1) N		John Class	tersin	MOT	o ser	ratts K	Athora	Clinta	MX20735
	Star Registra		31. Date filed (Month, Day, Year) JUL 2 2 200		ar's Signature	Si)			,	

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uanick 7/27/04

Deborah

			sn #23a&27	per me G83	rtificate	of L	tas Death				001	1 2	521	55
Physician		Name (First, Middle,	,						2. Date of De Month	ath Day	y Y	'ear	3. Time of	Death
/Medical Examiner			TER DEWEES give street and number; ROAD)	4b. City, To	JRMC		of Death	JULY		2004 County of FREDE	Death	2240	P ^M _
Funeral Director	5. Social Secu 217-28-	-7344	3. Sex 7. Aç 1½ M 2 ☐ F	ge (In yrs. last birthday 69 Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 30	th ay, Year) • 19	35 M	Birthplac Country (aryla	ce (State of d) and	r Foreign
Maryland a-f show lifed at	10a. State	10b. County ad Frede	rick	10c. City, Town or L								10d	I. Inside Cit	
h with the Marsta or 28a-fs	10e. Street and 8134	Number Apples Chu	rch Road		10f. Zip C		788			10g. Cit	izen of Wh		17	
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland it Health and Mental Hygiene. item 27 is marked other then "neturel", or Items 23a or 28a-f show other traumetic event. It will be a marked of the traumetic event. It will be a marked of the filed at the maryland by Funeral Director.	11. Marital Sta 1 Never 3 Widow	tus Married 2∰Marrie ed 4 □Divorced	12. Was Decedent Armed Forces? d 14 Yes 2 If If Yes, Give Year or Dates:	?	Was Deceder If Yes, specify		panic Orig Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black, Specify:	American White, etc	>.	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or any Injury or other traumetic event. It a Medical Evant once. To Be Completed by F	Elementary/	15. Decedent's Specify only highest Secondary (0-12)	Education grade completed) College (1-4or	(Give life.	dent's Usual C kind of work DO NOT use Mechan	done du retired)	tion uring most	t of workii	ng		ind of Busin	ness/Indus	stry	
aryland 2 should be filled a marked other umetic event. To Be Co	17. Father's Na	me <i>(First, Middle, Li</i> :lvin DeWe							(First, Middle			,	1110.	
2, Mar land 2 sho lealth and m 27 is m her traum	Pearl I	's Name/Relationshi		8134	Apples	. Chu		Road	A Poute Number. Thur	nont	, MD	21788	3	
Baltimore, sermit. Pages 1 ar separtment of Hea mportent: If item: my injury or other			□Removal from State	20b. Place of Disposers Resthaven	matory`or othe	er place,			04		cation - Cit erick			d
Ball permit Depart Impor eny In	1	Suneral/Service Li	omplications that cause	ρΙ	5 EAST	MA I	N ST	., T	ON FUNI HURMON	Г, МІ	HOME:	S, P. 88	Α.	
8760, cate be executed Animal Institution and institution and the burial-Iransit and the burial-Iransit and animal Examiner	Immediate Ca disease or cor resulting in de	use (Final dition atth) at conditions, thin ediate in a distention and in the conditions are injury ents	Due to (or as b	a consequence of): a consequence of):	osclero	otic	Caro	diova	ascular	Dis	sease	Ö	terval Betw	eath
Ords, P.O. Box 68 requires that the death certifica een signed by the attending ph hould be detached for use as th sted by Physiclan/Medl	IF FEMALE: 23b. Was dece in the pas 1 Yes 9 Unkn	t 12 months? 2 □ No	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3]Ectopic pregr] Other <i>(speci</i>					2	3d. Date o	f delivery Da	y Ye	ear
ords, P equires that een signed b ould be deta	Part II. Other s	gnificant condition	s contributing to death b	out not resulting in the u	nderlying caus	se given	in Part I.			obacco u res 2 [se contribu	te to the c	i.P	
I Rec The law ate has b page 2 si											24b. Wer prior dead 1 [X]	r to comple th?	findings avetion of cau	vailable use of
VISION OF Attending Phy. r death. ector: After this by the funeral d	examiner? XXYes 27. Manner of I XNatura 2 Accide 3 Suicide 4 Homic	Death 5 Pending investigat 6 Could no	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier Iny Year) 28b. Time o Injury ury - At home, farm, str c. (Specify)	28c.	Other: Injury a Work? 1 Ye	4 □ Nur	sing Hom 2	(Check only one 5 ☐ Reside 8d. Describe has been described by the second of the secon	lence 6 low injury	occurred			CFNE
spita ours verei	29a. Certifier (Check ont)	1 ☐ Certifying	Physician: To the best aminer: On the basis of	of my knowledge, deatl	occurred at t	he time	, date and	l place, a	nd due to the	ause(s)	and manne	or as stated	d.	
To the Hos within 24 h To the Fur completely Medic?	29b. Signature	and title of certifier	and manner sta	leath (Item 23a) (Type,	29c. Li O •	icense r	number •E			29d. Date AUG	signed (M	onth, Day 2004		
State	4	Month, Day, Year)	. MID	III Penr	Stree		Balti		e, Mary	land	2120	1		

State of Maryland / Department of Health and Mental Hygiene State RegistrAMEND ITEM #6 PER FH C834 8/19 10 11 1 OF THE OF Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Day **Physician** 14 10 PM Elben homas 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Maryland Medical Baltimore Cente. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**∑**M 2□F Director Delaware 214-90-4794 July 5, 1968 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "netural", or items 23s or 28s-f ehow the Medical Examinar must be confilled at 1 ☐ Yes 2√2 No Be Completed by Funeral Director Maryland Caroline Denton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 United States 26138 Share Highway 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mertal Hygiene. ent: if item 27 is marked other then "neturel; or the ury or other traumatic event, the Moutel Exercite ury or other traumatic event, the Moutel Exercite 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Caucasian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Welder Welding 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ruth Evelyn Wright Thomas Fleetwood Elben 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) T. Fleetwood Elben Father 26138 Shore Highway, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or 7/23/2004 Denton Cemetery Denton, Maryland Moore Funeral Home, P.A.

12 South Second Street, Denton, Maryland 21629

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 21. Signature of Funeral Service 22. Name and Address of Facility Approximate Interval Between Onset and Death 724r Immediate Cause (Final per Kalemia **Physician** disease or condition resulting in death) /Medical Due to (o **Examiner** untiam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Wilogonoma Physician/Medical Examiner Due to (or as a consequence of): ending physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 Z No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 1 Yes 2 No of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? the funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Atter 1 Natural 2 Accident 5 Pending 2 🗆 No death. investigation 1 TYes Director Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after o in by determined 4 THomicide 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signafture and title of certifier MO 385 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Punch 22 aune 31. Date filed (Month, Day, Year) 32. Registrar's Signature State (DONA) 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004^{Year} **Physician** August 1, 11:45 AMM Marguerite Virginia Fraley - /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town or Location of Death **Examiner** Rockville Shady Grove Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Pay, Year) Aug. 7, 1941 9. Birthplace (State or Foreign **Funeral** Marvland Days Hours 1 □ M 2 F 212-38-7887 Director Usual Residence of Decedent filed withIn 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 7 is marked other than "naturel", or itams 23a or 28a-f show treumatic event, the Navical Exactions from the Compiled at 1 ☐ Yes 2 No Mt. Airv Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 U.S.A. 14417 B Peddicord Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hisant: if item 27 is marked oth Christian O. Brashears Virgie N. Lamb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19317 Burnside Bridge Road, Keedysville, MD 21756 Carol A. Crouse, daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Resthaven Memorial Gardens Aug. 5, 2004 Frederick, Maryland 1 Burial 2 □ Cremation 3 □ Removal from State = 5 permit, Page Department of Important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signature of Funeral Service Licensee Charly. 21701 M00255 23a. Part 1. Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chiline. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUNTHU /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year ŏ Month Day 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate 1 ☐ Yes 2 No Be (director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Empatient 2 □ ER/Outpatient 3 □ DOA 2 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident o the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after ŏ o the Hospitei 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29d. Date sigged (Month,, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUG 1 1 2004 32. Registrar's Signature 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Ethel Rebecca Fandel Ju₁y 24 2004 5:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8834 Lew Wallace Road Urbana Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 💢 F 74 579-36-2362 Director Nov. 26,1929 Delaware Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28e-f show or other treumstic event. The Medical Examinar must be notified at Maryland Montgomery Damascus 1 ☐ Yes 2 📉 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 22501 Butterfield Way 20872 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be 2 should be finand Mental F Herman V. Morgan Anna Nickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
important: if item 27 is
any injury or other treu George E. Fandel/Husband 22501 Butterfield Way, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State All Souls Cemetery July28,2004 Germantown, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Saneral Service Ligensee Name and Address of Facility P.A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that cause of he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung cancer year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐ Yes 2X No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 2 No 2 🗆 No Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 KOther (Specify) Home Hospital: 1 | Inpatient ပ 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 1 XNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident completely filled in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Funerel Dire 6 To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45880 July 26, 2004 address of person who completed cause of death (Item 23a) (Type, Print) C. Hwang, M.D., 1396 Piccard Dr., Rockville, MD 31. Date filed (Month, Day, Year) 32. Registratr's Signature State JUL 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4UDI GATLIN Year **Physician** 2004 13=35 M TOHNNIE /Medical 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Min. | May 1, 1930 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HALFORD HARFORD MEMONAL HOSPITAL Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**)** ∑ M 2 □ F 429-56-4729 Mississippi Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ir then "neturel", or Items 23a or 28e-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 🔀 No Aberdeen Harford MD Director 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?

15 Yes 2 □ No

16 Yes, Give
Year or Dates:

13. Was

15 Yes, specify

1 □ Yes 2 ▼ No Specify:

1 □ Yes 2 ▼ No Specify:

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

18. Mother's Name (10f. Zip Code 10e. Street and Number U.S.A. 730 Schofield Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married & Married 21215-0036 Specify:Black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) U.S. Army 12 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) T is mark Mammie Williams James Gatlin Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 730 Schofield Rd., Aberdeen, MD 21001 Pages 1 and 2 ment of Health a Brigitte Gatlin (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State R. A. Ferris & Co.Inc. 8/5/04 Department o Importent: If any injury or once. West Chester, PA * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name, and Address of Facility Tarring—Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 permit. ran Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC CANCER Pnysician /Medical Due to (or as a consequence of): Examiner PROSTATE CAZUNOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown o 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CORONARY ARTERLY DISEADE 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CONGEDING HEART FAIL autopsy performi 1 Yes 2 No 1 ☐ Yes 2 ☐ 🗯 HY (OTHYNOIDIS M Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 K Yes 2 □ No Certification: To ð 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ŏ within 24 hours a

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completely filled o the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DMG 021809 mush

State Registrar

State 31. Date filed (Month, Day, Year) sistrar AUG 1 1 2004

32. Registrar's Signature

2336 YOUR LD

TIMONIUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRASHUMD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ALMOND CHESTER GUSHEE 6:30 26 2004 A^{M} JULY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Dealh 4b. City, Town, or Location of Death Examiner Charles Charlotte Hall 7820 Tall Oaks Place If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 18 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2 □ F Hours 81 Massachusetts Director 010-24-5813 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygliene. Important: if item 27 is marked other than "natural", or Itama 23a and 25 and injury or other traumating. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Charles Charlotte Hall Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20622 USA 7820 Tall Oaks Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status l CXYes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Marned 1 ☐ Yes 21 No þ Specify: Specify: White 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedeni's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Religious Ministry Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruth Stone Gushee Chester W. Gushee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3624 Guilford Ave. Indianapolis, Indiana 46205 Daniel P. Gushee (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Mullein Hill Baptist Ch. 7-31-04 Lakeville, MA 4 Donation 5 Other (Specify) 21. Signature of Fupe al Service Licenses 22. Name and Address of Facility ^{22. Name and} Address of Facility Eberwein Funeral Services 4433 White Pls. La. White Pls., MD 20695 MOQ173 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximale Interval Between Onset and Death shock, or heart failu Immediate Cause (Final ODYSPLASTIC SYNDROM **Physician** MYEL /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Lasl Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatienl ٩ Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation М 2 Accident filled in by the 6 Could not be determined 3 □ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 61

Registrar DHMH 17 Rev 1/2001

State

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

31. Date filed (Month, Day, Year)

JÚL 2 8

03

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 17:55 M Samue1 Lee Irvin 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Deeth Examiner Union Memorial Hospital Baltimore Baltimore City 8. Date of Birth (Month, Day, Year) Nov. 5, 1954 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 511-58-9887 Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F 49 Kansas **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Items 23a or 28a-f show the Medical Examiner must be notified at Yes 2□No **Funeral Director** Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 828 C Littlestown Pike 21157 United States deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Maritat Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail Manager traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Health and Mental Health and Mental H Be Forrest E. Irvin Janice Morrison Verrone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 a Depertment of Health ar Important: If Itsm 27 is a sny injury or other traut 2002. Monica Holter/Sister 210 Ross Lane, Bluemont, VA 20135 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, Stete Baltimore Crematory at LP 7/11/04 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 6 / 1040 Rockville Pike Rockville, MD a 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Septic Immediate Cause (Final Shock **Physician** disease or condition resulting in death) dai /Medical Due to (or as a consequence of) **Examiner** Peritoniti Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed of imhosis resulting in death) Last Due to (or as a consequence of): Physician/Medical repatiti use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy be detached for in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an enc autopsy performed? Ce 1 ☐ Yes 2 🗷 No 1 Tes or Attending Physician: funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 XNo 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Watural after death. 1 🔲 Yes 2 🗆 No 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number AT 2438946-E21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID. 201 East University Parkwa. woker had 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 6 2004 Registrar

		1	1 - State Registrar	State of Marylar	•	artment of He			ene g. No?	Marine and Marine and	2527	70
			Decedent's Name (First, Middle, Last,					2. Date of Death	1	1 6.5	3. Time of D	eath
	Physici		Clago	gett Aloy:	sius	Jones		Month August	Day 2	Year 0 0 4	1:25	A^{M}
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or I	Location of Death		4c. County	of Death		
п		•	Frederick Memo	rial Hospi	tal	Frede	rick		Fre	deri	ck	
	Funeral		5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 Hrs.		161	9. Birthp	lace (State or a	Foreign
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	D.		Usual Residence of Decedent					<u> </u>				
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	ith th	Oire	10e. Street and Number	1		10f. Zip Code		10	g. Citizen of \		itry?	
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23a or 28a-f show Its M. cifeal Examinational Demolified at	by Funeral Director	2381 Bear Den Ro	ad		2170)1		U,S.	Α.		
	r dea	Inei	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	1	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp. Mexican, Puert	pecify Yes or No- o Rican, etc.)		e - Americ		
9	or It	F	1 Never Married 2 X Married	1 X Yes 2 No194. If Yes, Give	3-	1 ☐ Yes 2 ☑ No	Specify:	•	Specify		_	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or flems 23a or 28a-f show any injury or other traumatic avant, I've Marcal Examination at the notified at Once.		Mrs. Jean N. Jone			ng Address (Street a						
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	707 e 0		owner.	1 Jungan MOO		06 East Ch	urch St	, Frederi	ck, Ma	rylar	d 2170	1
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	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	,		_			0	
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0	e de the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of a 9 Unknown	death 5[Other (specify)					J a, 13	
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0 _	D e		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Injury Work	at ?	28d. Describe ho	w injury occur	red		
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Division	I or Attandir after death. I Director: Af d in by the fu	tifle	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Speci	iome, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Numb . State)	er or Rura	l Route Numbe	ar,
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	To the Hospital within 24 hours a To the Funerel I completely filled	Σ	29b. Signature and title of certifier			29c. License		25	d. Date signe			
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	10		30. Name and address of person who o	ompleted cause of death (Ite	т 23а) (Туре,	, Print)				•		
_	10		A. Austin Pearre	Jr, M.D., 30	00 West	Ninth St	reet. Fr	ederick.	Marv1	and 2	1701	
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Sign		1 .			,			
	Regist	rar	AUG 1 1 2004	X JET TO THE STATE OF THE STATE		AMA H.			1			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 6876

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. JASON R. KELLY State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 3:18 P M Jason Ryan Kelly 31, JULY 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WASHINGTON COUNTY HOSPITAL WASHINGTON HAGERSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 15 M 20 F 15 Yrs. 212-31-4415 September 13,1988 Director VÃ Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10b. Count 10d. Inside City Limits or 28a-f show instrust be notified at 1 ☐ Yes 2√ No Completed by Funeral Director Berkeley Springs Morgan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Pious Ridge Road 25411 USA 238 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ò 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Student Education 7 is marked other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fil ment of Health and Mental Hent: If item 27 is marked ott jury or other treumatic even Richard L. Kelly Tammy L. Rittersback 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Kelly/Father 76 Pious Ridge Rd. Berkeley Springs, WV 25411 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State pełmit. Page Department o Importent: If any injury or once. 1 4 ☐ Donation 5 ☐ Other (Specify) St.Peter's Catholic 108/04/04 Hancock, MD 21 Signature of Juneral S wice Licentee 22. Name and Address of Facility 141 West Main Street Grove Funeral_Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Injuries Prosician Multiple disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): by Physician/Medical use as ding IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ▼ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No o the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Yes 2 No Other: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: motor wehile struck 1 Natural 5 Pending Passenger of 1 ☐ Yes 2 No death. investigation 7-31-04 14 = 30 P M 2 Accident i Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Fairview Dr. 4 Homicide within 24 hours after To the Funerel Dire Springs. Berkeley Koad Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E AUG. 1, 2004 W. mil

State Registrar

31. Date filed (Month, Day, Year) AUG 1 1 2004

LING LI. M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

souls

111 Penn Street, Baltimore, Maryland 21201

			For State Registrer	State of Marylar	•			ealth an Death	nd Me	, ,	iene _{eg. Ng} ? () () (4	252	76
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	Funeral		Social Security Number 6. S			If Unde	Days	If Under 24 Hours	Hrs. 8	. Date of Birth (Month, Day,			place (State ntry)	or Foreign
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	ter de Item	ů	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	1.5.	If Yes, sp	ecify Cuba	spanic Origin n, Mexican, F	uerto Ric	fy Yes or No- can, etc.)		Race - Ameri Black, White,		
36	rs aff	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2X №	Specify:			Spe	ecity: whi	te	
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Maryland 21215-0036	illed Hygid other ent,	Be C	17. Father's Name (First, Middle, Last,					18. Mother's	Name (f	First, Middle, I	Maiden Sur	name)		
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ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylar to Health and Mental Hygiene. If item 27 is marked to the than "natural, or liems 23a or 28a-1 show if item 27 is marked to the than "natural, or liems traumatic event, Ite Medical Examinat must be rolliked at		20a. Method of Disposition		Place of Dispo	osition (Na	me of	- !	Dat			on - City or T	own, State	
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Baltimore,	permit. Pages 1 and Department of Healinportant: If item 2 any injury or other once.		21. Signature of Funeral Service Licer			_		,		es Fun			1	
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ta		e C	25. Was case referred to medical					26 Place of	f Doath //	1 Yes 2	2 No	1 🗆 Yes	2□No	
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of	y Phy eral c		27. Manny of Death	28a. Date of Injury	28b. Time o		28c. Injury Work			d. Describe ho		- ' '	(y)	
lo	nding th: : Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year)	Injury	М		(? Yes 2 ∐No						
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		nome, farm, st	reet, facto	ry, office		28	f. Location (SI City or Town	reet and N n, State)	umber or Run	al Route Nun	nber,
	Hospital 24 hours a Funeral I	edical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medicel Exer	nysician: To the best of my kn niner: On the basis of examin	owledge, deat ation and/or in	h occurre vestigatio	d at the tim	e, date and pointon, death	place, and occurred	d due to the ca at the time, d	ause(s) and ate and pla	d manner as s ce, and due t	stated. the cause(s)
	To the within 2 To the Complet	Med	29b. Signature and title of certifier	and manner stated.		20	c. License	number		2	9d. Date si	gned (Month,	Day Year	
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	6			Naganna, M.D	. 700	_	∞le	Road	₩e	estmins	ter,	MD 211	57	
• -	Sta Regist		31. Date filed (Month, Day, Year) ALIC 1 1 2004	32. Registrar's Sign	A	lone	//							

DHMH 17 Rev 1/2001

MENIN MONROE KEEFER

Physic	ion	1. Decedent's Name (F	First, Middle	e, Last)							Date of Dea		Year	3. Time of Death
/Medi		Richard		C		Lan	denbe			Z	August			0915 A
Exami	ner	4a. Fecility Name (If no			and number)		4	b. City, Town,		eath			ounty of Death	
Euparal		Memorial 1 5. Social Security Num		Call 6. Sex	7. Age	(In yrs. last	t birthday)	Cumbe: f Under 1 Year	If Under 24	Hrs. 8.	Date of Birt	h .	Allegar 9. Birth	place (State or Fore
Funeral Director		215-26-69	1	1 X M 2[onths Days	Hours	Min.	Date of Birt (Month, Day Nar 20	y, Year) 1. 192	9	PA
2		Usual Residence of De	ecedent		-									
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28a-f	Director	10e. Street and Number					Cambe	10f. Zip Code				10a Citiza	en of What Cou	
tams 23a or 28a-f shorer realities at		313 Penns		ia Aver	nue				21502			rog. Onize	USA	unity:
ms 2	Funeral	11. Marital Status	o y i v ai i	12. Wa	is Decedent E	ver in U.S.	13. Wa	s Decedent of I		? (Specify	Yes or No	- 14	. Race - Amer	
or its		1 Never Married	. –	ied 1.	Yes 2 N	0	ĺ	es, specify Cub IYes 2. Mo		netto Hica	an, etc.)		Black, White	e, etc.
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jiene. r than "natu If e Medicul	Completed	(Specify	only highes	t's Education of grade comp			16a. Deceden (Give kin lite. DO	t's Usual Occup d of work done NOT use retire	pation during most of d)	working		16b. Kind	of Business/l	ndustry
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otha vant,	Be C	17. Father's Name (Fir		Last)			10	<u></u>	18. Mother's	Name (Fi				
nd Menta markad matic e	70 6	Ernest \	W. Laı	ndenbe	erger				Heler	า G. (Show	man)	Lander	nberger
E 00 E		19a. Informant's Name		hip (Type, Prir				Address (Street						
f Health itam 27 i		Doris Tab			sister			ake Gor			Bedfo			15522
0		20a. Method of Dispos	Cremation		Il from State			on (Name of ory or other pla		Date			ation - City or T	
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Depa impo any ii			1	7 10	UNA	1// =	22.19	Scarpel	li Funera	Home	e, PA			
		23a. Part Fenter the	disease, or	complications	s that raused	the death.	Do not lonter t	108 Vir	ginia Avel	nue: C	umber spiratory ar	land, N	AD 21502	2 Approximate
		shock, or heart fa	ailure List	anhi ana asus	e on each line					0100 01 10	opinatory ar	1031,		, opioxiiii ato
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			1 - For Amend item 5 883 1 - Registrar AMEND ITEM #22	e 910Maryland / E PER FH C834	Department of L 87 Timent of L Certificate of	lealth and Mental I Death	Hygiene
	Physici	an	1. Decedent's Name (First, Middle, Last) Harry C. Lennox			2. Date o	
	/Medio		4a. Facility Name (If not institution, give street ar		4b. City, Town, o	r Location of Death	4c. County of Death
	LXamii		SACRED MEART NO	soital.	Cumbe	Rland	AlleGany
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	Months Days	If Under 24 Hrs. 8. Date of Month	f Birth 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	70	Yrs.	4	4-1934 Maryland
	land ow		10a. State 10b. County	10c. City, Town	n or Location		10d. Inside City Limits
	Mary	호	MD Allegany	LaVal	е		1 □ Yes 2y ᢓ No
	h with the	al Director	10e. Street and Number 70 LaVale Court		10f. Zip Code 21502	2	10g. Citizen of What Country?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examble must be invilled at	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ If Ye	Decedent Ever in U.S. ad Forces? Yes 2 No s, Give	13. Was Decedent of Hif Yes, specify Cuba	dispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc. Specify:	r No-) 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	tural	ed b	15. Decedent's Education	r or Dates:	Decedent's Usual Occup	pation	16b. Kind of Business/Industry
215	nin 72 in "na Mediti	piet	(Specify only highest grade comple	eted) ege (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most of working	Tob. Aind of Business/Haustry
21	d will giene er the	Completed	12 4		Teacher		Education
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, The M	To Be (17. Father's Name (First, Middle, Last) Harry P. Lennox			18. Mother's Name (First, Mic Caroline (V	^{ddle, Maiden Sumame)} izza) Lennox
_	and 2 should leath and Menion 27 is markener traumation		19a. Informant's Name/Relationship (Type, Prin Carole Lennox – wi			and Number or Rural Route Nu Court, LaVale	umber, City or Town, State, Zip Code) e, MD 21502
Baltimore,	Pages 1 a nent of Hei int: If itam iry or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	cemeter	Disposition (Name of ry, crematory or other place rest Mem.	Park 8-5-04	20c. Location - City or Town, State Cumberland MD
Baltii	permit. Pages 1 and 2 Department of Health s Important: If itam 27 li any Injury or other tra once.	Ì	21. Signature of Funeral Service Licensee	toler Jy	22. Name and Addre	ss of Facility Hafer	Funeral Service PA LaVale, MD 21502
and the second	Pnysician /Medical		23a. Parn. Enter the disease, or complications shock or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that a se the eath. or one on each ine.	HUCARDIA	1.1000	Approximate Interval Between Onset and Death
8760,	death certificate be executed a attending physiclen and ad for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence of the to (or as a consequence of t	of):		
O. Box 6	that the death certificated by the attending placed for use as t	Physician/Med	in the past 12 months?	s, outcome of pregnancy Live birth 2∏Fetal death Pregnant at time of death Unknown	3 □Ectopic pregnancy 5 □ Other (specify) □	,	23d. Date of delivery Month Day Year
rds, P.	quires that in signed b uld be deta	by	Part # Other significant conditions contributing	to death but not resulting in	the underlying cause giv		Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
I Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed				a	Vas an utopsy findings available prior to completion of cause of death?
Vital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?			26. Place of Death (Check or	
of V	S . S	ဥ	1 Yes 2 No Hospital:	1 Inpatient 2 ER/Ou		4 Nursing nome 5 F	Residence 6 Other (Specify)
n C		lon			Fime of 28c. Injury		ibe how injury occurred
Division	l or Attending Phefer death. Director: After the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, fa building, etc. <i>(Specify)</i>		Yes 2 □No 28f. Location City or	on (Street and Number or Rural Route Number, Town, State)
_	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: Afte completely filled in by the fune	Medicai Ce	(Check only 2 Medical Examiner: On	To the best of my knowledge the basis of examination an manner stated.	e, death occurred at the tir d/or investigation, in my d	ne, date and place, and due to pinion, death occurred at the til	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	Fo the within Fo the	ğ.	29b. Signature and title of certifier		29c. Licens	e pumber	29d. Date signed (Month, Day, Year)
)	·- > F 0		I Handin William	m	D/L	6041	08-02-04
	10		30. Name and address of person who completed	I cause of death (Item 23a)	(Type, Print)	V / /	
	10		Terry William mo	. Memoria	I moderal i	Boldg, Lumb	Sexland Mol. 21507
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 1 2004	32. Registrar's Signature	Some		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death クロウブ Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** DONNA JEAN LARGENT JULY 19 2004 2.31p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 20, 1969 Birthplace (State or Foreign Country)
 MD 5, Social Security Number 7 Age (In vrs. last birthday) **Funeral** 214-92-3738 1 ☐ M 2 🖫 F 34 Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits show the Medical Examiner must be notified at MD Washington Hagerstown TX Yes 2 No Director or 28e-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 630 W. Franklin St. 21740 U.S.A. or items 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress restaurant 12th grade 0 . Pages 1 and 2 should be filed vitment of Health and Mental Hygie tant: If item 27 is marked other? jury or other traumatic event. other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Carol H. Childs Be Lewis W. Largent 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leo R. Cove husband 630 W.Franklin St. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) July 23, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Big Pool, MD permit. Page Department of Important: If any injury or once. Parkhead Cemetery 2004 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Subarachono.d hemornhous 12h /Medical Due to (or as a consequence of): Examiner Cerebral aweur 40ars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 9 Unknown 9 TUnknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 9 NO Division of Vital To the Hospitel or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 T Homicide within 24 hours a To the Funeral L 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hohen straperes 54619 3H-1 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 141 Thomas Johnson Drive Frederick, MD 21702 Dennis Winters 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 28 2004 Registrar

				State of Maryland / Dep		Mental Hygie	ene	
			State Registrar	Ce	rtificate of Death		1. No.2 1 1 1	25278
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) EVELYN VIOLA CUE	BITT LAMBERT		JULY 23	3 2004 Pear	12:00 PM
	Examin		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death	n	4c. County of Death	
			SHADY GROVE ADVE		MONTGOMERY			
	Funeral Director		218-05-19361	7. Age (In yrs. last birthday) M 2 S F 90 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	MAY 21	^{9. Birth}	place (State or Foreign htry) MD
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Marylan I-f show fied at	tor	MD MONTGON	MERY GERMANT	NWO			1 MYes 2 □ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. If the marked other than "natural", or Itams 23a or 28a-f show tiem 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Marcical Examination at	by Funeral Director	10e. Street and Number 19219 LIBERTY MI	ILL ROAD	10f. Zip Code 20874	10g	g. Citizen of What Cour	ntry?
	death ms 23	era	11. Marital Status	2. Was Decedent Eyer in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
5-0036	urs after death w at', or Itams 23a	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	o Hican, etc.)	Black, White,	_
2-0	72 hours "natural",	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Dece	dent's Usual Occupation kind of work done during most of wor	king 16	b. Kind of Business/In	dustry
2121	within ene. than "r	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired) STANT POSTMAST		POSTAL S	ERVICE
	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	ASSI		ne (First, Middle, Ma		EKVICE
Maryland	2 should be filed within and Mental Hygiene. Is marked othar than aumatic evant, the M.	To Be	FRANK CUBITT			ETH LUHN		
	1 and 2 shi Health and Iem 27 Is m		19a. Informant's Name/Relationship (Type PAT ZIMMERMAN /		ing Address (Street and Number or Ru 39 BLACK ROCK R			
ore,	ges 1 and of the or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place of Disponentery, cre	matory or other place)		c. Location - City or To	own, State
Ë	Pa men ury		'4 □Donation 5 □ Other (Specify)	MONOCAC	CY CEMETERY 7/	28/04	BEALLSVI	LLE, MD
Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Fundial Service Licenser	H	2. Name and Address of Facility IILTON FUNERAL P.O. BOX 86, BA		.E MD 2	0838
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RESPIRATORY ARE	REST DUE TO CER	EBROVASO	ULAR	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	INFARCTION			
		-	Sequentially list conditions, if any leading to immediate	LARGE CEREBROVA Due to (or as a consequence of):	SCULAR INFARCT	ION		3 days
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	,				
oʻ	icate be executed physician and s the burial-transit	Еха	resulting in death) Last	Due to (or as a consequence of):				
68760,	cate be ex physician the buria	dlcal	d.					
_	0	w	IF FEMALE:					
Вох	death certif e attending id for use as	Physician/M	in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ery Day Year
P.O.	00	yslc	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 5[9□Unknown	Other (specify)			
	requires that the een signed by the nould be detache	by Ph	Part II. Other significent conditions cont	ributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
rds	w requires been sign should be					1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
Records,	s b	Completed	0			24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
	The ate h	Com				performe	d?/ death?	2 No
/ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	1		th (Check only one)		
of Vital	Phys this al dii	J.	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Outpatie	The second secon		ce 6 Other (Specific	y)
no	ding h. After fune	tlon	1 atural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division	Attanding r death. actor: After by the fune	Certification;	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st		28f. Location (Stree	et and Number or Rura	il Route Number,
Di	al or / after 1 Dira d in b	erti	4 Homicide determined	building, etc. (Specify)		City or Town,	State)	
	To the Hospital or Attantwithin 24 hours after deating the Funaral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my knowledge, deal er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place evestigation, in my opinion, death occu	, and due to the causerred at the time, date	se(s) and manner as si e and place, and due to	ated. the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifier		29c. License number	29d	I. Date signed (Month,	Day, Year)
			() Inv	irkcaldex	182120		7/23/200	٧.
	10			npleted cause of death (Item 23a) (Type	, Print)			
	17		Robert Kirke		1 Medical Center D	rive Kock	wille, MD	20850
	Sta Registi		31. Date filed (Month, Day, Year)	32 Alegistrar's Signature	& Sparker			

	š		For State Registrar	State of I	Marylan	d / Depa		of H	ealth a			giene	25279
	Physici	2 n	1. Decedent's Name (First, Middle, L	ast)							2. Date of Dea Month		3. Time of Death
	/Medic		PATRICIA ANN			-					8	3 20	MACIC 1400
	Examir	er	4a. Facility Name (If not institution, g		er)				Location of			4c. County of	
	Funeval		CARROLL HOSPITA 5. Social Security Number 6.		Age (In yrs.	last birthdav)	If Under		INSTE		8. Date of Birth		ROLL Birthplace (State or Foreign
	Funeral Director		216-36-4965 Usual Residence of Decedent	1□M 2□F XX	72	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day AUGUST	21,1931	(UNKNOWN)
	arylan show	_	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits
	28a-f	ecto	MARYLAND CARE	OLL	l I	MANCHES		0 . 1 .				0.00	1 Yes 2 No
	with t	ä	10e. Street and Number 4526 HANOVER PIR	Œ			10f. Zip	2110:	2			10g. Citizen of What UNITED	
ter death	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mudical Extra directional be notified at ance.	Completed by Funeral Director	11. Marital Status YNever Married 2 Married	12. Was Decede Armed Force	s?		If Yes, speci	fy Cubai	n, Mexicar	gin? (Spe 1, Puerto l	cify Yes or No- Rican, etc.)	Black,	American Indian, White, etc.
<u>8</u>	ours a	d b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	A s:		1 ☐ Yes 2	XNo	Specify:			Specify:	WHITE
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ر م	Hygi other ent,		17. Father's Name (First, Middle, La	st)		l	110111		18. Mothe	er's Name	(First, Middle,	Maiden Sumame)	
ılan	uld be Mental irked tic ev	To Be	(UNKNOWN)						(UNKN	OWN)		
Baltimore, Maryland	and 2 sho alth and 1 27 is mu er traumu		19a. Informant's Name/Relationship EDWARD CROUSE/CA				ng Address HANO\				l Route Numbe NCHESTE	r, City or Town, St R, MD 2	ate, Zip Code) 1102
	Pages 1 and of He		20a. Method of Disposition 1	Removal from Sta	ite C	Place of Disponentery, cremetery, remetery, cremetery, cremetery, cremetery, cremetery, cremeter, cremetery, cremeter, creme	matory or ot	her place		s/5/2	004	20c. Location - Ci	ty or Town, State AD, MARYLAND
Balti	permit. Departrimports any Inju		21. Signature of Funeral Service Lic		RBORA IS SI	W FU	NERAL H	OME, P.A MINSTER,	MD 21157				
			23a. Part . Enter the disease, or co shook, or heart failure. List on	mplications that cau	sed the deat	h. Do not ent	er the mode	of dying	g, such as	cardiac o	r respiratory arr	rest,	Approximate Interval Between
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	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):							
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9	rtificat ng phy as th	g	IF FEMALE:								V-1.		
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	law requires that the de as been signed by the a 2 should be detached f	by	Part II. Other significant conditions SMAIL boc	contributing to deat		-	nderlying ca	use give	n in Part I	•	23e. Did to	1	ute to the cause of death?
Records,	The his age	Completed	large Re	moperi	twee	al b	leed	ng		-	24a. Was a autop: perfor	sy prid med/2 dea	re autopsy findings available or to completion of cause of the cause o
Vital	ysician: is certifical director, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or		7103 2010
کر د	S S	은	1 ☐ Yes 2 No	Hospital: 1 X Inp		ER/Outpatier		_	4 🗆 140			ence 6 Other	
n C	ing Afte une	lon:	27. Manner of Death 1 Natural 5 ☐ Pending		njury Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe h	ow injury occurred	
Division of	ten Jeat tor: the	ficat	2 Accident investigat 3 Suicide 6 Could not	be 380 Blace of	Injury - At he	ome, farm, str	M reet factory		/es 2□	-	28f. Location (S	treet and Number	or Rural Route Number.
Ω	in the	Certification:	4 Homicide determine	building	etc. (Specif	y)	oot, lactory,	Onico			City or Tow		or ristal riosto ristrigor,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basi and manner	s of examina	wledge, deat tion and/or in	h occurred a vestigation,	it the tim	e, date an pinion, dea	d place, a	and due to the co	ause(s) and mann date and place, and	er as stated. If due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier				29c.		number			29d. Date signed (
			Titimas	K. 600	آ سىل	11	_	D3	166	0		08/03	12004
	1		30. Name and address of person when the second seco	o completed cause		n 23a) (Туре, 2		TON	er.	AUR	we w	esmin's	STER may have
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	Regist	rar	AUG 1 1 200	4 Gene	رجنس	D.	Soon	sol					

_			1 - For State Registrar	State of Maryla	nd / Dep			ental Hygie	_		2 0	200
	Physici	an	1. Decedent's Name (First, Middle, L	,				2. Date of Death Month	Day	Year	3. Time o	Death
	/Medi	cal	FRANCIS MILLER					8	3	04ª	1300	Рм
	Examir	ner	4a. Facility Name (If not institution, g	ive street and number)			or Location of Death	Ì		ty of Death		
	Funanci	-	304 Northeast Road 5. Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday)	Aberdeen If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	на	rford	ologo (Ctato	os Fornina
	Funeral Director	2	216 30 635 4	1ØM 2□F 69		Months Days	Hours Min.	(Month, Day, Y September		34 Cou	plece (State ntry) PA	or Foreign
	yland		10a. State 10b. County	10c. C	City, Town or Le	ocation					10d. Inside C	ity Limits
	Mar Hed	tor	MD Harford	1	Aberd	een .					1 Yes	2 🗌 No
	ith the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen o	What Cou	ntry?	
	efh w		304 Northeast Road			21001			U.S	.A.		
936	be filed within 72 hours after deeth with the Maryland ntal Hygiene. ed other than "natural", or itams 23a or 28a-f show event, the Medical Exam are must be revitted at	by Funeral	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 2 Yes 2 No If Yes, Give Year or Dates: 1953-		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1 No	dispanic Origin? (Spe an, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)		ace - Ameri ack, White, ify:		
Baltimore, Maryland 21215-0036	hin 72 hor n. "natura medical E	Completed	15. Decedent's (Specify only highest g	Education		dent's Usual Occup kind of work done DO NOT use retire	pation during most of workind)	ng 16	b. Kind of	Business/Ir	dustry	
21	giene giene ar tha	ĕ	12	0		Chemical Wo	orker		Chem	iæls		
P	be filed tal Hygid d other	Be	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, Ma.	iden Suma	ıme)		
<u>ya</u>	2 should be and Mental ie marked o	2	Asby Miller	Alene Jen	nings							
Jar			19a. Informant's Name/Relationship				and Number or Rura			n, State, Zij	Code)	
o)	l and lealth om 27 her tr	. 8	Shirley Miller (Wife				d, Aberdeen,					
وّ	permit. Peges 1 and 2 Depertment of Health a Important: If item 27 is any injury or other tre once.		1 ☐ Burial 2 MCremation 3	Removal from State	cemetery, cre	osition (Name of matory or other pla	ce)		c. Location	- City or T	own, State	
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Ba	permit. Depertr Importa any inju	1.	21. Signature of Furieral Service Lice	1 6/11-			Funeral Hon					
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•	Physician /Medical Examiner	5: 3	23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	1 - 0	aluro			Tospiratory arrost			Approxima Interval Bei Onset and	tween Death
Rigidal States	ite be executed ysicien and ne burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Due to (or as a conse	equence of):	phaged	cancer				4 mi	onths
587	<u>a</u> × a			d								
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificete has been signed by the affending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preging the preging the second of	tat death 3	Ectopic pregnance Other (specify)	/			ate of deliver	_	Year
o_	thet	by Pt	Part II. Other significant conditions	contributing to death but not re	sulting in the u	Inderlying cause giv	en in Part I.	23e. Did tobac	co use cor	ntribute to t	he cause of o	Jeath?
rds	quires n sign							1 🗆 Yes	2 🗆 No	3 Prot	ably 4	Jnknown
00	w rec	Completed						24e. Was an	24h	Were auto	psy findings	available
Be	The le	E						autopsy performe	d2	prior to co death?	mpletion of a	ause of
ital	an: '	0	25. Was case referred to medical				26. Place of Death	(Check only one)	No	1 🗆 Yes	2∐ No	
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2[☐ ER/Outpatier	nt 3 DOA Oth		ne 5 Residenc	e 6 🗆 Ot	her (Specif	iv)	
0	ng Pt fter ft neral		27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur		8d. Describe how			,,	
Sio	endin eath. or: A	Sation	2 Accident investigati	on	,		Yes 2 □ No					
Divis	ital or Att irs after d ral Direct	Certification:	3 Suicide 6 Could not determine	building, etc. (Spec	city)			81. Location (Stree City or Town, S	State)			ber,
	the Hosp nin 24 hou the Fune pletely fil	Medical	one)	Physician: To the best of my kr aminer: On the basis of examination and manner stated.	nowledge, deat nation and/or in	vestigation, in my o	pinion, death occurre	d at the time, date	and place	, and due to	the cause(s	.)
	with To Con		29b. Signature and title of certifier	n 0		29c. Licens	2 3 8 0 9	[ed (Month,		
	Et1		7. auto	in Wagle m			20001		Hugu	st 4	, 2004	<i>t</i>
	5		30. Name and address of person who				. 22 6 1	- C1	P	11		12 - 1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign		encer ctr	-, 22 S- C	rune st	1 00	W.	MD 2	1201
	Regist	40	ANG 1 1 200		4	door de						

		1 - State Registrar 1. Decedent's Name (First, Middle, Las		ryland / Dep		Health and M	Mental Hy	giene Reg. No 2004	2528
Physicia /Medic Examin	al	June 4a. Facility Name (If not institution, give St. Vincent dePai	E. street and number) ul Nursing H		4b. City, Town, o		Aug 5,	Day Year 2004 4c. County of Death Allegany	
Funeral Director		5. Social Security Number 6. Stransport 199-46-6629 1 Usual Residence of Decedent	744 007	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Jun 2	9. Birth (6, 1914	nplace (State or Foreig untry) PA
8a-f ehow	Director	MD 10b. County Allega	ny	10c. City, Town or Lo Fros	tburg				10d. Inside City Limit
23e or 2	ral Dire	10e. Street and Number 48 Tarn Terrace			10f. Zip Code	21532		10g. Citizen of What Cor USA	untry?
irs a	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of HIF Yes, specify Cubin	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Specify:	nican Indian, o, etc.
within 72 ene. then "nat he Medic	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5-	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	king	16b. Kind of Business/I	ndustry
be tile ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Victor Smail	-	TIOTIC	18. Mother's		ne (First, Middle, (unk) Sı	Maiden Sumame)	
har 7 ie trau	V	19a. Informant's Name/Relationship (1 Rebecca Mizak	ype, Print) daug	hter 266	ng Address (Street S National	and Number or Rui Highway	ral Route Numbe LaVa	er, City or Town, State, Z	ip Code) ID 21502
permit. Pages 1 and Department of Heali Important: If Item 2 eny injury or other ance.		20a. Method of Disposition 1)	Westmore	matory or other place land Co. Me	em.	8/10/2004	20c. Location - City or 1 Greensbur	
ysicie	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):	ory of	scare			5 911.
000	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1	Fetal death 3	□Ectopic pregnancy	,		23d. Date of deliv	very Day Year
igne be d	by	Part II. Other significant conditions of Demontia	ontributing to death bu	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to 1 ☐ Y	obacco use contribute to	the cause of death?
ate h	Completed							prior to commend? death? 1 Yes	opsy findings availab empletion of cause of 2 No
al dji	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) Injury	f 28c. Injur Wor M 1 🗆	y at	ome 5 Resid	dence 6 Other (Speci	
to the hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		4 Homicide determined 29a. Certifier Certifying Ph	building, etc.	my knowledge, deat	h occurred at the fir	ne, date and place	and due to the c	cause(s) and manner as	Stated
within 24 h	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of and manner stat	examination and/or in	29c. Licens	pinion, death occur e number	red at the time, o	date and place, and due to 29d. Date signed (Month,	Day, Year)
5		30. Name and address of period who of Dr. Sunil K. G			Print)			Ang 5, 200	
Sta Registra		31. Date filed (Month, Day, Year) AUG 1 1 200	32. Registra	r's Signature	Some de		, FID 21.	302	

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

ANA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD

111 Penn Street, Baltimore, Maryland 21201

J.4-4/48 MAN		1 - State AMENDITEM	State of Marylan #4a&26 PER ME				nd Ment		ene a. No. 11 11	1.	25200
Blueia		1. Decedent's Name (First, Middle, Last	1)					ate of Death	600 113 113	Year	3. Time of Death
Physic /Medi		Nathan Willi					J	uly 21	2004		0710 A M
Exami	ner	4HEBREW HOME SUFFIGER 6105 Montrose A		ION	4b. City, Town, Rockvi		Death		4c. County		
Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Da	ate of Birth fonth, Day,	Mont		LY place (State or Foreign
Director		054-07-3864	X ^{M 2□ F} 86	Yrs.	Months Days	Hours	Min. (A	fonth, Day, 1	1917	Cour	necticut
pu &		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	eation					1.	10d. Inside City Limits
Jaryle Short	ō										1 Yes 2 No
28a-	Director	Maryland Montgome 1 10e. Street and Number	<u>y</u> 511	ver Sp	10f. Zip Code			10	g. Citizen of W	/hat Cour	
h with	a Di	3330 N. Leisure Wo	orld Blvd., #5	517	20906			Ur	ited S	tate	S
ems 2	Funeral	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Origi	in? (Specify Y	es or No-	14. Race		can Indian,
s after, or it	by Fu	1 ☐ Never Married 2 😿 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 19	42-	1 ☐ Yes 2 👿 No			,,	Specify:	:	
within 72 hours after death with the Maryland with in the Maryland ene. then "neturel", or Items 23e or 28e-1 show he Marical Examinet must be mailted at	ed b	15. Decedent's Ed	Year or Dates:	16a. Dece	dent's Usual Occu	pation		1	6b. Kind of Bu	Whi	
d within 72 hours aff giene. er then "neturel", or	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most	of working	'			
giene giene the	Son	201101111111111111111111111111111111111	4	Ac	countant	:		(Governm	ent	Accounting
Indi yidii d	Be	17. Father's Name (First, Middle, Last)	. •				's Name (Firs	t, Middle, M	aiden Sumam		
y Ica	P		rtin	405 14-15	Add (Ct	Rose			Rudm		
d 2 st d 2 st th and th and treun		19a. Informant's Name/Relationship (7) Rae S. Martin, v									Code/20906 Spring, MI
Heal Heal Hem 2		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of		Date		Oc. Location - 0		
diffillore, mit. Pages 1 ar partment of Hea portent: If item y Injury or othe		1 XBurial 2 ☐ Cremation 3 X 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	•	natory or other pla Ld Mem. ('	/25/20	04 F	alle Ch	urch	, Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Ie marked other then "neturel", or Items 23a or 28a-1 show any Injury or other treumstic event. The Marical Examinat must be notified at once.		21. Signature of Funer I Service Licen	7	22	2. Name and Addr	ess of Facility					is ATTRIBLE
		Josey In.	Mi	1	dward Sa 091 Rock	ger ru ville	neral Pike,	Direct Rockvi	110n, 1 11e, M	nc. D 2	0852
		23a. Part1. Enter the disease, or composhops, or heart failure. List only	lications that caused the deal one cause on each line.								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a. Atherosclevo	tic Ca	rdiovus	ellar	disea	U2			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
*	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):						-	
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	0								
e exectant an an an an an an an an an an an an an	Exa	resulting in death) Last Due to (or as a consequence of):									
GO COU, ificate be executed g physician and as the burial-transit	dlcal	•	d								
		IF FEMALE:	22a. If upp. autnama of progn	2004					Ι.		
The law requires that the death certifica the has been signed by the attending propage 2 should be detached for use as it	by Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Feta 4☐Pregnant at time of c	aldeath 3	Ectopic pregnant	су			23d. Date Mor		ery Day Year
the d	ysic	1 Yes 2 No 9 Unknown	9 Unknown	J.			, ,,,				
s that	y P	Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	ndertying cause g	iven in Part I.	2	3e. Did toba	acco use contr	ibute to the	he cause of death?
w require	ed t							1 🗌 Yes	2 □ No	3 🗌 Prob	pably 4 Unknown
TECOLUS, The law requires t te has been signe age 2 should be	Completed						2	4a. Was an autopsy		Vere auto	ppsy findings available
The The page	Con						1	perform	ed? d	leath?	2 No
vital siclen: T certificate irector, pe	Be	25. Was case referred to medical examiner?	Hasnital:				of Death (Che	eck only one)		
ding Physicien: The Inding Physicien: The Inding Physicien: The Inding Physicien Inding Physician Physicia	. To	XXYes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatier	IT 3 DUA				nce o El Ot he		y) At-seenc
DIVISION I or Attending after death. Director; After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	W	ork? □Yes 2□N		2630(106)(10)	v injury occurre	XI.	
Atten r deal	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At h	iome, farm, sti			28f. L			er or Rura	al Route Number,
s afte	Cert	4 Homicide	building, etc. (Speci	iry)				ity or Town,	State)		
To the Hospitel or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the fune		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my kn- niner: On the basis of examin	owledge, deat	h occurred at the	time, date and	place, and d	ue to the car	use(s) and mai	nner as s	tated.
the H hin 24 the F nplete	Medical	one)	and manner stated.								
J. With	~	29b. Signature and title of certifier	MID			nse number			d. Date signed		
•			That is a second of the second	m 93-1 (~		.M.E.	-		July 2	c, 20	JU4
		30. Name and address of person who a	m '>	m 23a) (Type,		enn Str	reet, E	Baltim	ore, Ma	aryla	and 21201
, St	tate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature							
Regis	trar	AUG 1 0 2004	heren 1	9 1.	m Kall						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2,200.4 **Physician** AUGUST 9:43P FATHER ALOYSIUS THOMAS NEWMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** CHAS.CO.NURSING & REHAB.CENTER CHARLES LAPLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Yrs. Director 082-18-3945 JULY2,1923 NEW YORK Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Machical Examinar must be notified at 1 Yes 2 □ No LA PLATA MARYLAND CHARLES Direct 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2√☐No f Yes, Give Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. ent: if item 27 is marked other than CATHOLIC PRIEST ARCH.OF WASHINGTON 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM W. NEWMAN MARGARET MURRAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 BEACH 135th ST. ROCKAWAY PARK, N.Y.11694 CATHERINE HOPKINS-SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State riment of XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Depertment Importent: If eny injury o SACRED HEART CEMETERY 8-9-04 LA PLATA, MARYLAND M00479 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNÉRAL SERVICE, P.A. PLATA, MARYLAND 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initieted events resulting in death) Last the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9☐ Unknown s been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 3 autopsy 25. Was case referred to medical examiner? certificate 2 No or Attending Physicien: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2010 ۵ 2 ER/Outpatient 1 Tes 1 Inpatient 3□ DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? Director: After 5 Pending investigation 1 DNatural death. М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo HENRY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 1 2004 Registrar

Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal Arlene Aletha Punt Aredinal	10d. Inside City Limits 1 □ Yes 2 □ No 10g. Citizen of What Country? USA s or No- etc.) 14. Race - American Indian, Black, White, etc.
Examiner 4a. Facility Name (If not institution, give street and number) Reeder's Nursing Home 5. Social Security Number 218–40–3826 Usual Residence of Decedent 4b. City, Town, or Location of Death Boonsboro 7. Age (In yrs. last birthday) Yrs. 4b. City, Town, or Location of Death Boonsboro 1 Under 1 Year If Under 24 Hrs. (Months Days Hours Min. Jan.) Jan.	Washington te of Birth Ponth, Day, Year) 31, 1931 PA 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Director 218–40–3826 Usual Residence of Decedent 1 M 2 T	Country) 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc.
106. Street and Number 54 N. Main Street 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rican, 1 Tyes 2 GuNo	USA 14. Race - American Indian, Black, White, etc.
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Year In Type 2 (No)) 1 Never Married 1 Never Married 2 Married 1 Never Married	
If Yes, Give 1 ☐ Yes 2 √ No Specify:	Specify: White
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Shipping/Purchasing clerk	16b. Kind of Business/Industry
The part of the pa	Middle, Maiden Sumame)
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route 10704 Timothy DR Willi	amsport, MD 21795
20a. Method of Disposition Second	Broad Street Waynesboro P.
23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respin shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 3 Ectopic pregnancy 5 Other (specify) 24d. 25d. Female	23d. Date of delivery Month Day Year
Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23 24 24 24	e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Triknown
The law for a state of the stat	a. Was an autopsy performed? Yes 2 \(\begin{array}{ll} \text{No} \end{array} \) 24b. Were autopsy findings available prior to completion of cause of death? 1 \(\begin{array}{ll} \text{Ver} & 2 \(\begin{array}{ll} \text{No} \end{array} \)
To be a compared to medical examiner? 1	k on one □ Residence 6 □Other (Specify)
The second of th	scribe how injury occurred
The street of th	ation (Street and Number or Rural Route Number, y or Town, State)
29a. Certifier 1	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
D 18019	AVC 1, Zooy
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Vasant Datta 340 Mills Street Had State 31: Date filed (Month, Day, Year) 32. Registrar's Signature	gerstown, MD 301-739-710

			For State Registrar	State of M	aryland / De	partment o		nd Mei		jiene eg. No:)	01.	25000
	Physici		1. Decedent's Name (First, Middle, Last GEORG	•	PA	RMELEE			Date of Dea Month ULY 2	Day 20	Year	3. Time of Death)
	/Medio Examin		4a. Facility Name (If not institution, give			SYKE	wn, or Location of	Death		4c. County CARI	of Death	
	Funeral Director		5. Social Security Number 6. Se 158–10–3379 Usual Residence of Decedent	X 7. Ag XM 2□F 8	e (In yrs. last birthd 4	Months D	ear If Under 2	Min. J	Date of Birth (Month, Day une 11	,1920	9. Birthp Cour I1	lace (State or Foreign try) linois
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event, Ita Medical Examinal must be notified at once.	Funeral Director	10a. State 10b. County Maryland Frederick 10e. Street and Number 3724 Lawson Road		10c. City, Town o				İ	l0g. Citizen of \	Vhat Cour	•
9036	ours after death ral', or Itams 23 Examiner must	þ	11. Marital Status 1 Never Married 2 Married 3 Xiddowed 4 Divorced	12. Was Decedent Armed Forces? 1 2 Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 1		t of Hispanic Origi Cuban, Mexican,	in? (Specif Puerto Ric		United States No. 14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	ad within 72 hogiene. er than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 4	(G lif	cedent's Usual O ive kind of work a e. DO NOT use r puter Pr	fone during most (retired)	of working		U.S.		cnment
Maryland	t should be filed within and Mental Hygiene. s marked other than "sumatic event, If a Men	To Be (17. Father's Name (First, Middle, Last) Paul R. Parmelee	0.11			Maria	an E.	Princ			
	i and 2 sh Health and tem 27 is n		19a. Informant's Name/Relationship (7. Elizabeth Stavely 20a. Method of Disposition		Ijan 20b. Place of Di	sposition (Name)	of			r, City or Town,		
Baltimore,	artment of ortant: If it injury or o		1 🕅 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License)	Parklawi		ry 0	7/27/	2004	Rockvil	le,	
Ba	Depar Impo any ir		Indil O	Wenn	d the death. Do not	26401 Ri	Molesword Molesword idge Road things such as o	d. Da	mascus	. MD 2	lome 0872	Approximate
	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or companies, or heart failure. List only of the class of condition resulting in death) Sequentially list conditions,	a Due to (or as		epsis					•	Intérval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Discourse or injury that initiated events resulting in death) Last	c	a consequence of):							
P.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 □Ectopic pregr 5 □ Other (specia					te of delive	ory Day Year
	w requires tha been signed should be del	by	Part II. Other significant conditions co		out not resulting in the	e underlying caus	se given in Part I.			bacco use cont es 2 No		ne cause of death?
Vital Records,	The law ate has b page 2 st	Completed							24a. Was a autop: perfor 1 Yes	med?/	Were auto prior to co death? I □ Yes	psy findings available npletion of cause of 2 No
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other /		Check only or			
Division of	fter	ation; To	1 Yes 2 No 27. Man of Death 1 atural 5 Pending 2 Accident investigation	28a. Date of Inju	and the second s		Injury at Work?	280		ence 6 Oth		1)
Divis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be determined	building, e	jury - At home, farm tc. <i>(Specify)</i>				City or Tow	n, State)		l Route Number,
	n 24 hou ne Funei	edical	29a. Certifier 1 V Certifying Ph (Check only 2 Medical Examone)	ysicien: To the best liner: On the basis of and manner si	of examination and/o	eath occurred at t r investigation, in	the time, date and my opinion, death	d place, and h occurred	due to the cat the time, o	ause(s) and ma late and place,	inner as s and due to	ated. the cause(s)
	To the within To the comp	ž	29b. Signature and title of certifier	m (poet	MO		icense number	13	2	29d. Date signe		Day, Year)
(1		30. Name and address of person who of		death (Item 23a) (Ty	L	ivite 30		10 etu-	0 /	Mo	21157
	Sta Regist		31. Date filed (Month, Day Year) 2	1 40	ray's Signature	3	442) ·	/	- 311111			and the last of th

		` .	1 - For State Registrar	State of M	aryland		artment of H		and Mental Hy	giene Reg. No.	004	25287	
1	Physici /Medic		Decedent's Name (First, Middle, La LOUELLA RIDEN						2. Date of De Month JULY	ath Day 29	2 0 0 4	3. Time of Death 3:01 P M	
	Examir		4a. Facility Name (If not institution, gi FREDERICK MEM			L	4b. City, Town, or FREDE		of Death	4c. County of Death FREDERICK			
1	Funeral Director		5. Social Security Number 6. 215-42-4109		ge (In yrs. Ia 73	If Under: Hours	24 Hrs. 8. Date of Bir Min. (Month, Da October	13,1	9. Birth <i>Col</i> 930 Mai	nplace (State or Foreign intry) ryland			
	show show	J.	Usual Residence of Decedent 10a. State 10b. County			Town or Lo		-				10d. Inside City Limits 1 □XYes 2 □ No	
	Maryland Washington Maugansville 10e. Street and Number 10g. Citizen of What										en of What Cou		
	h with	ai Di	13935 Maugansvi	lle Road			2176	67			.S.A.		
336	ırs after deal al', or Itams : கள்ளாசா ப	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Yes 2 1 If Yes, Give Year or Dates:	?		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 📉 No	lispanic Origan, Mexican Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
1215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any njury or other traumatic event, it is Modical Examiner must be notified at ances.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Cook					of working		Kind of Business/Industry			
d 2	illed Hygid other	Be Co	17. Father's Name (First, Middle, Las	t)				18. Mothe	r's Name (First, Middle,				
Maryland 2121	should be find Mental hind markad of	ToB	Max Rineha		ohrer	19b Mailir	on Address /Street		ary Re	becca		Johnston	
	alth ar 27 is ir trau		B. Lee Ridenour	Son					Hagerstown				
altimore,	es 1 a of Hea fitam rotha		20a, Method of Disposition 1 XBurial 2 Cremation 3	Ramaval from State	20b. Pla		sition (Name of natory or other place		Date		ation - City or T		
Ĕ	Pages tment of tant: If its		4 ☐ Donation 5 ☐ Other (Spec	(ty)	Rest		n Cemeter		08-02-04			, Maryland	
Ba	Depar Impor any in		21. Signature of Funeral Service Licensee Afrida W. Coffman Funeral Service Licensee Archange and Address of Facility Archange and Address of Facility 40 East Antietam Str								Inc. town. N	Md. 21740	
	Physician		Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition			Do not ent	er the mode of dyin	g, such as	cardiac or respiratory as	rrest,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Dusso (or as	a conseque							72 6	
	D #	iner	Sequentially list conditions, if any, leading to introduction cause. Enter Underlying Cause (Disease or injury	Due to (or as			•					sean	
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	conseque	ence of):	en-					years.	
68760	physicial physicial the buri			d									
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25t No 9 □ Unknown	,		23	23d. Date of delivery Month Day						
rds, P.	quires that in signed b	by	Part II. Other significant conditions		out not result	ting in the u	nderlying cause give	en in Part I.	23e. Did to			the cause of death?	
Vital Records,		Completed		nen					24a. Was autor perfo	an osy rmed?	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of	
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: A.			Othe		of Death (Check only o			*	
	Phys er this eral dir	To To	1 Yes 25 No 27. Manner of D. ath	28a. Date of Inju	iry 2	R/Outpatien 28b. Time of		4 🗀 Nui	rsing Home 5 Resid			fy)	
lon	Attanding Physician: The in death. ector: After this certificate hiby the funeral director, page	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ıy Year)	Injury	28c. Injury Work M 1 🗆 '	k? Yes 2⊡1		,			
Division of	ospital or Attan hours after deat unaral Director: ly filled in by the	Certification:	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of in	jury - At horr tc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and i vn. State)	Number or Rur	al Route Number,	
	To the Hospital or At within 24 hours after of To the Funaral Direct completely filled in by	edical C	29a. Certifier Certifying P	hysician: To the best miner: On the basis of and manner st	of examination	ledge, death on and/or inv	occurred at the time restigation, in my op	ne, date and pinion, deat	place, and due to the hoccurred at the time,	cause(s) ar date and p	nd manner as s ace, and due t	stated. to the cause(s)	
	To the To the Comp	Σ	29b. Signature and title of certifier				29c. License			29d. Date :	signed (Month,	Day, Year)	
•	,) one	- Na4.		ر 	D18	414		7-6	504		
	k		30. Name and address of person who	HAN, M	0,10	23a) (Type,	Print) -J.D. #	120	7. Frico	GRI	cls Ma	21702	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1. 1. 2004	32. Regist	rar's Signatu	9	back						

				- Ot-4-	partment of Health and I ertificate of Death	-	giene Reg. No. 0 () 4	2528	88
		Dhysia	o m	Decedent's Name (First, Middle, Last)		2. Date of De	ath	V	3. Time of	Death
		Physici /Medi		PHILIP ISAAC RYTHER		July	Day 17 2	Year 2004	5:35	P^{M}
	7	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	3	4c. Count	y of Death		
				Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Bethesda If Under 1 Year If Under 24 Hrs.			gomer		
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	Months Days Hours Min	8. Date of Birt (Month, Da	y, Year)	9. Birth	place (State of ntry)	r Foreign
		ס		Usual Residence of Decedent		Feb. 19	, 1915	Mini	nesota	
		deeth with the Maryland ms 23a or 28a-f show	_	10a. State 10b. County 10c. City, Town or	Location				10d. Inside Cit	y Limits
		8a-1 s	Funeral Director	Virginia Arlington					1 🗌 Yes	2 X No
		with th	D P	10e. Street and Number	10f. Zip Code		10g. Citizen of	What Cou	ntry?	
		eeth v	era	4015 N. Upland Street	22207		USA			
	10	Iter d	Ë	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 □ Never Married 2 □ Married 1 □ ∑ Yes 2 □ No	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- Rican, etc.)	- 14. Ra	ice - Americ ack, White,		
	036	urs a	þ	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1941 = 1945	1 ☐ Yes 2 💢 No Specify:		Speci	ty: Wh	ite	
	5-0	be filed within 72 hours after deeth with the Marylan ha! Hygiene. Id other than "nature!", or items 23a or 28a-f show event, the Medical Evand actions to confiled at	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation		16b. Kind of E	Business/In	dustry	
	21	ithin ithin	gu	Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor a. DO NOT use retired)	ang				
	2	tygier ther th	ပ္ပ	5+ Owne			Real Es		Compar	ıy
	ano	ntal H ed of	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam					
	Z	hould Me mark matic	2	Lionel Ryther 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Edna (Ma ailing Address (Street and Number or Ru					
	Ma	od 2 s lith an 27 is trau			Heatherwood Place					
	re,	f Hea f Hea item			sposition (Name of rematory or other place)	Date	20c. Location			
	E O	Page ent o nr: if		A Define 2 defination 3 different state	rematory or other place) l Memorial Park 7/2	22/04		-		
	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Evant and DOGS.		- Itaciona	22. Name and Address of Facility MONEY & KING FUNE		FAlls C	murci	ı, va.	
	m	9 9 1 8 8		May R Dounes	MONEY & KING FUNE 171 W. Maple Ave.	CRAL HOM	E, INC.	22180	1	
	r			23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory an	rest,	22100	Approximate Interval Betw	1
10		Physician		Immediate Cause (Final disease or condition MENING-0	NCEPHALITIS				Onset and D	eath
3		/Medical Examiner		resulting in death) Due to (or as a consequence of):						
1		LAGIIIIICI	<u>.</u>	Sequentially list conditions, b.						
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						
0		axecu al-tra	xar	that initiated events resulting in death) Last C. Due to (or as a consequence of):						
,	8760,	ne death certificate be executed the attending physicien and hed for use as the burial-transit	dicai							
1	9	tificat ig phy as th	ledi	<u> </u>						
+	Вох	th cer endin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	D∏Satonia arangan		23d. Da	ate of delive	iry	
12	Э. В	ed for u	sicis	1 Yes 2 No	3 □Ectopic pregnancy 5 □ Other (specify)		Mo	onth	Day Ye	ear
En	P.0	that the ed by th detache	Phy	9 □ Onknown						
0	S,	es pe	þ	Part II. Other significant conditions cognitiviting to death but not resulting in the STROKE. PNEUMONIA	underlying cause given in Part I.		bacco use con			
	Orc	neen Inou	etec	= 11.0100 11.		1 U Y	es 2 No	3 Prob	ably 4.5Ur	nknown
7	Records,		Completed			24a. Was a autops	an 24b.	Were autor	psy findings av	vailable use of
工		ilcian: The lav certificate has rector, page 2:		25 W		1 Yes	mea	death?	2(X No	
0	Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 25.No Hospital: 12-Inpatient 2 ☐ FR/Outpatient	26. Place of Deat					
V	o	Phy er this	-	27. Manner of Death 1	lent 3 DOA 4 Nursing Ho	me 5 Reside			")	
(3)	ion	Attending r death. sctor: After y the fune	atlo	1 Satural 5 Pending (Month, Day Year) Injury 2 Accident investigation	of 28c. Injury at Work? M 1 Tyes 2 No		, ,			
7	Division	r Atte er de: recto by th	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (SI	treet and Numb	oer or Rurai	Route Number	ΘΓ,
5-		ital or rs afte el Dire	Cer	building, etc. (Specify)		City or Towi	n, State)			
		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director Affer this certificate has completely filled in by the funeral director, page 2	ical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de. 2 Medical Examiner: On the basis of examination and/or and manager stated.	ath occurred at the time, date and place,	and due to the care	ause(s) and ma	anner as st	ated.	
		To the within 2 To the 2 Complete	Medical	and manner stated.						
	١.		-	29b. Signature and title of codifier	29c. License number	1 2	29d. Date signe	d (Month, L	Day, Year)	
	, (8+1		30 No.	02657		T/2	010	4	
				30. Name and address otherson who completed cause of death (Item 23a) (Typ. IRVING MIZUS MD 10215 F	ERNWOOD RD #401	BETHE	ES DA, M.	070	817	
		Sta	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature			- 1		011	
		Registr	ar	JUL 22 2004 Beneva B	ppacks					

			For State Registrar	State of Mar	-	artment of H			jiene	L 25280
	Physicia	an	1. Decedent's Name (First, Middle, Last) $Raik K.$					2. Date of Dea Month	Day	3. Time of Death Year 204 05 30 p M
>	/Medic Examin		4a. Facility Name (If not institution, give	5, rgh		4b. City, Town, or	Location of De		4c. County	
	LAGIIIII	C1	Shady Grove Adven		tal	Rocky	ville			gomery
	Funeral		Social Security Number	7. Age (In yrs. last birthday)	If Under 1 Year Months Days			1	Birthplace (State or Foreign Country)
	Director		217-23-0686	M 2₩ F	78 Yrs.			June 13	1926	India
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary First	tor	Md. Montgome	ry	Gaith	ersburg				1 ☐ Yes 2 🕱 No
	th the	Director	10e. Street and Number			10f. Zip Code	 -		10g. Citizen of V	Vhat Country?
	ath wi	ral	1008 Queens Orc	hard Rd.		208	378		Inc	lia
	er de i	nne		12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race Blac	e - American Indian, k, White, etc.
39	urs aft	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:		1⊡Yes 2√∑MNo	Specify:		Specify	Asian Indian
Š	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ont, I'na Medical Examinat must be notified at	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	and time	16b. Kind of Bu	siness/Industry
215	thin 7	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done o DO NOT use retired	during most of v	ronking		
2	led w lygier har th	Co	4 /4 /4 /4 /4 /4 /4 /4 /4 /4 /4 /4 /4 /4		H	omemaker	40 14-15-1-1			ome
Maryland 21215-0036	ntal Hed of	Be	17. Father's Name (First, Middle, Last) Damodar	Singh				ame <i>(First, Middle,</i> nand E		θ)
Ž	2 should be f n and Mental H is marked of raumatic ever	<u>د</u>	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Street		Rural Route Numbe	r. City or Town.	State. Zip Code)
	nd 2 saith ar 27 is 27 is r trau		Tirlok Singh (Son					. N.Potor		
Jre,	ss 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. Location -	City or Town, State
Ĕ	Page ment ant: If ant of		1 ☐ Burial 2 至 Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Chambers	Cremato	ry7/	22/04		ale, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licens	hamke		Name and Addressematorium	m, P.A.	hambers F 5801 Clev	uneral l eland A	Home & 20737 ve.Riverdale,Md.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the	ne death. Do not ent	er the mode of dyin	g, such as card	iac or respiratory are	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. 5 e	psis					Onset and Death 2 weeks
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	uted d ansit	Examine	cause. Enter Underlying							=======================================
oʻ	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):					
8760,	ate be hysici the bu	dical		d						
9	leath certific attending p	/Med	IF FEMALE:	12a If was subsame of	Orange and a					
Вох	death certific e attending p id for use as	by Physician/Me	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year
o.	0 0 0	ysk	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9□ Unknown	110 01 000111 012					
σ.	requires that the reen signed by th hould be detache	y P	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	ribute to the cause of death?
rds	w require been sig should b	ed k	pulmonary ?	toxicity				1 □ Y	es 2. No	3 ☐ Probably 4 ☐Unknown
eco	aw as b	Completed						24a. Was a autop		Vere autopsy findings available prior to completion of cause of
æ	The ate h page	Com						perfor	med?	death?
Vital Record	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	In a situate		100		eath (Check only or	ne)	
of	S &	To.	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpatier		4 🗆 Marsing	Home 5 Resid		
on	ding Ih. After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	Year) Injury	Wor	k? Yes 2 □ No	250. 563610611	ow injury occurr	eu
Division	il or Attending after death. Diractor: After	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury	/ · At home, farm, str					er or Rural Route Number,
ā	s afte	Certification:	4 Homicide	building, etc.	(Specify)			City or Tow	n, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (sician: To the best of oner: On the basis of each manner state	xamination and/or in					nner as stated. and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Licens		1	29d. Date signed	(Month, Day, Year)
•	21		Mito le	son &	77	6	15 49	4	7/21	12004
	V		30. Name and address of person who co	mpleted cause of dea	ith (Item 23a) (Type,	Print)		i		•
			Christine Lepou			al Center	r Dr. Ro	ockville,	Md. 208	350
	Sta Registr		IIII 23 20	32. Registrar	3 Signature	Sporks				

Box 68760 Division of Vital Records, P.O.

/Medical **Examiner** attending physician and for use as the burial-transit The law requires that the death certificate be executed the certificate has Hospital or Attending Physician: funeral director. this After death. after death 24 hours a ths

Physician

Physician

/Medical

Completed by Funeral Director

Be

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event.

Physician/Medical þ Completed Certification:

Medical

Examine

within 2. To the F 2 State Registrar

6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 814/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

04/41

MM

6570 Kenilworth ane, Suite 2100, Riverdale. MIS METIRU MASTER MIT 31. Date filed (Month, Day, Year) 32. Registrar's Signature

NO050514

AUG 1 1 2004

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Drivin 17 Rev 1/2001

			For State Registrar	State of Maryland /		artment of Hortificate of L		Reg	ene . No.2 () () ()	25291
No.	Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) MARY CA'THER1			4b. City, Town, or	10		Day Year 0,2004 4c. County of Dea	3. Time of Death 5:30P
Ar A	Examin Funeral Director	1	4a. Facility Name (If not institution, give s 1683 ATKINSON 5. Social Security Number 578-03-6791		irthday) Yrs.	COBB If Under 1 Year Months Days	ISLAND If Under 24 Hrs. Hours Min.		CHARL (ear) 9. Bir	
	a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARI	10c. City, To	wn or Lo	cation COBB IS				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3a or 28	i Dire	10e. Street and Number 1683 ATKINSON			10f. Zip Code	0625	10	U · S · A ·	ountry?
980	be filed within 72 hours after death with the Maryland and bytylene. do other than "natural", or items 23a or 28a-f show do other than "natural", or items 23a or 28a-f show event, the Mudical Examinar from the notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 10 No If Yes, Give A Year or Dates:	'	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes a☐ No	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
21215-0036	I within 72 ho iene. r than "natur the Wedical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of wor	king	Sb. Kind of Business	
	t be filed ntal Hygi ed other event, t	Be	17. Father's Name (First, Middle, Last)	OMAY			18. Mother's Nan	ne (First, Middle, Ma	iden Sumame)	io D
Maryland	2 should be and Mental is marked sumatic ev	T ₀	JAMES F • I 19a. Informant's Name/Relationship (Type		b. Mailir	ng Address (Street a		L M • NO	City or Town, State, .	Zip Code)
	1 and Health am 27 ther tr		KATHRYN KILINSKI 20a. Method of Disposition			ATKINSO	ON CO		ND , MD . 2 Oc. Location - City or	
mor	Peges nent of I ant: If its ury or o		1 □ Surial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State cernet	ery, crer	natory or other place	1	_		, VIRGINIA
Baltimore,	permit. Peges Depertment of Important: If II eny injury or once.		21. Signature of Funeral Service License	M00479	, Per	RAYMOND T.A PT.ATA	s of Facility FUNERA A, MARYI.	L SERVIO	CE,P.A.	
6.8	Physician /Medical		23a. Part1. Enter the disease, or complications, heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. The eat on each line. Due to (or as a consequence	he	er the mode of dying	3	or respiratory arres	t,	Approximate Interval Batween Onset and Death
760,	physicien and physicien and sthe burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figury that initiated events resulting in death) Last	Due to (or as a consequence						
.O. Box 68	The law requires that the death certificate ite has been signed by the atlending phys page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregpant in the past 12 morths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
<u>α</u>	quires that n signed b	by	Part II. Other significant conditions con	tributing to death but not resulting	in the u	nderlying cause give	n in Part I.			o the cause of death?
al Records,	ician: The law requir certificate has been si rector, page 2 should	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of 2 No
ion of Vital	ding Phys n. After this funeral di	ation: To Be	27. Mann Death 1 Natural 5 Pending 2 Accident investigation	1	Outpatier Time o Injury	f 28c. Injury Work	^{rr:} 4 □ Nursing H at	ome 5 Pesiden 28d. Describe how	ce 6 □Other (Spe	rcity)
Division	i Sir G	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, st	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my knowled ner: On the basis of examination a and manner-stated.	ge, deat and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the cau rred at the time, dat	se(s) and manner as e and place, and du	s stated. e to the cause(s)
)	To the within 5 To the comple	Med	29b. Signature and title of certifier	Hand		29c. License		Annual Control of the	d. Date signed (Mont	th, Day, Year)
6	Sta Registr		30. Name and address of person who control address of person who control and address of person who control add	mplefed cause of death (Item 23a 32. Registrar's Signature	(Type,	Sirooke Sould	56.S	ite 104	Walder	f,mb acco

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 August 4:28 PM CHARLES FRANCIS STOUT, JR. /Medical 4a Facility Name (If not institution, give street and number) Civista Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner La Plata, MD Charles | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | Note | 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign Country) PA **Funeral** 1☐M 2□ F Months Days Yrs. 222-26-3237 61 Director Usual Residence of Decedent 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits YE Yes 2□ No Funeral Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10045 HARMONY HILL LANE 20646 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 1√2 Yes 2 □ No If Yes, Give 7 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: ARMY ģ 3 ☐ Widowed 4 ☐ Divorced WHITE 1964 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 C MPUTER ANALYST BUREAU OF THE CENSUS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES F. STOUT, SR. ELIZABETH MABEL BOWDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NAN STOUT-SPOUSE 10045 HARMONY HILL LANE LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 19 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) T TRINITY MEM.GARDENS 8-6-04 WALDORF, MARYLAND M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Major gratial Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

injury

should be fi is marked

inaries

Attending Physician: The law raquiras that the death cartificate be executed

by Physician/Medical Examiner Completed within 24 hours after death. To the Funeral Director: After this certifica completely fillad in by the funeral director, Be Medical Certification: To

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 Yes 25No

27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a Certifier

4 I Homicide

5 Pending investigation

6 Could not be determined

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No

3 □ Probably 4 DUnknown 24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify)

28b. Time of 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 29c. License number

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

29d. Date signed (Month, Day, Year) D-28035 08-01-2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Basirmohmad Kolia, MD 9135 Piscataway Rd., Suite 210, Clinton, MD 20735

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 1 2004



24 hours

within 2

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Margie Schmidt Ju_{1y} 27 2004 /Medical 8:18am^ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St Mary's Nursing Center Leonardtown St. Mary's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sev 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 23,1921 Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖼 F 468-18-3616 Director 83 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f show Examiner must be collified at 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26121 Woody Ct. 20659 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. be filed within 72 hours after 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ◯XNo Specify: White 3XWidowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be if Health and Mental Fred Leroy Ethe1 Gertrude Heller Peges 1 and 2 should ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanne E. Dove (Daughter) 26121 Woody Ct. Mechanicsville, Maryland 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July Datom2004 20c. Location - City or Town, State 0 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Important: If any injury or once. Resurrection Cemetery Clinton, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Fuheral Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** erdmovascu /Medical Examiner artherosclerotra cerebrovascular diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached fo 4□Pregnant at time of death 5 Other (specify) □Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by urmany tract infection, 1 Yes 2 No 3 Probably 4 Unknown been Stroke on 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? to Gastrointest new bleetin dise discu 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA this in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of After 1 28d. Describe how injury occurred 5 Pending investigation 1 Natural s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 51738 7.27.2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KATE T. AUNG, 24435 MERVELL DEAN RD., HOLLYWOOD MD 20636 32. R strar's Signature State 2004 Registrar

		•	1 - For State Registrar	State of	Marylan		artment rtificate			and Me	ental Hygi	iene g. No. 0	04	252	294
	Physicia	an	Decedent's Name (First, Middle, Last) MADV. TOUL CULTURE COLUMN								2. Date of Death Month JULY	Day	Year 004	3. Time 1:45	of Death P
	/Medic	_	MARY LOU SHIFT 4a. Facility Name (If not institution, give		ber)		4b. City,	Town, or	Location of	of Death	JOHI	~	ty of Deati		
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	Funeral Director		5. Social Security Number 6. Sec. 1213-24-8887	M 2⊠F	'. Age (<i>In yr</i> s. 75	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, MAY 30,	1929	MAI	nplace (State untry) RYLAND	or Foreign
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ດ	"natural",	Completed	15. Decedent's Edu (Specify only highest grad	cation le <i>completed)</i>		(Give	dent's Usua kind of wor DO NOT us	k done	during mos	t of workin	g	16b. Kind of	Business/	ndustry	
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<u> </u>	s 1 and 2 should f Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (7) SUSAN SOUDERS/DAU				•	,			Route Number, BORO, MAI				
	s 1 and f Health item 27 other tr		20a. Method of Disposition	GILLER	20b. F	Place of Disponentery, cre	osition (Nan	ne of				20c. Location			
altımore,			1 ⊠ Buriol 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)		tate	ONSBOR			100	7/29/				MARYL	AND
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Juneral Service License		1 M. De		2. Name an AST FU			HVLH:	7606 01d Boonsbor				713
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O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		irth 2 ☐ Feta ant at time of c	aldeath 3	⊒Ectopic pr ⊒ Other (sp		<i>y</i>				Date of deli Month	ivery Day	Year
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	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Phyone) 2 Medical Exem	iner: On the ba	best of my kn asis of examin ner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the ti	me, date a opinion, de	nd place, a ath occurre	ed at the time, d	ate and plac	e, and due	to the cause	
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			30. Name and address of person who o	completed caus	e of death (Ite	MU) m 23a) (Tvne	, Print)	03	920	0		1/ 2	110	7	
_			Dr. Angela Manns	S	113	30 Opa.		ct,	Hager	stown	, Maryl	and 2	21742		
	St Regist	ate	31. Date filed (Month, Day, Year) JUL 28 20	04 32	egistrar's Sign	d.	rede								

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State of Manyland / Department of Health and Mental Hygiene

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<u> </u>	should but marked	ှ	Jesse C. F.				19b. Mailin	a Address (Stree	t and Number or Ru	E. Robis		State. Zip (Code)
	nd 2 ith ar ith ar trau		G. Rohert Sn			nđ		atertown		rlin, MI			,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23e or 28e-f show any Injury or other traumatic event, tre Medical Examiner must be notified at once.		20a. Method of Disposition	-		20b. P	lace of Dispos	sition (Name of atory or other plana	aca)	Date	20c. Location -	City or Tow	m, State
Ë	Pages nent of I int: If ite		1 ☑ Burial 2 ☐ Cremate 4 ☐ Donation 5 ☐ Other			Sus	squehan	na Carol		8-6-04	York,	РΔ	
alti	mit.		21. Signature of Funeral Ser			мет	22.	Gardens Name and Addr	ess of Facility	-	TOLK	IA	
ä	Depa Impo any i		Muchal	0 14	1.16	MW20	, B	urg Fun	eral Home	, Inc.	- DA	17256	
			23a. Part1. Enter the diseas shock, or heart failure.	e, or compl	ications that cau	used the death	n. Do not ente	r the mode of dy	roadway ing, such as cardiad	or respiratory a	rrest,		Approximate
1	Physician		shock, or neart failure.	List only of	nue caluse on eed	cn line.						1	nterval Between Onset and Death
7	/Medical		Immediate Cause (Final disease or condition		ENI	STA	GE 1	ENAC	D15	EASE			lur
	Examiner		resulting in death)	•		Due to (o	r es a consequ	uence of):				i	7-77-
	be sit	edical Examiner			DIA	BET	ES	MEL	LITUS	- 2		1	1EARS
1	aath certificate be axecuted attanding physician and I for use as the burial-transit	Xan	Sequentially list conditions, if env. leading to immediate			Due to (o	r as e consequ	ience of):				1	
68760,	be a	<u>8</u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	~ .	C							i	
587	phys s the		resulting in death) Last			Due to (or	as a consequ	ience of):				1	
Box	centifi nding use a	2			d								
	d for	by Physician/M	Part II. Other significant con	ditions cor	atributing to deal	th but not resu	ulting in the un	derlying cause o	von in Part I	23h Did	nhacco use co	otribute to 1	the cause of death?
P.0	t the by the tache	رد ا			-		-			10	5.7		ably 4 Unknown
	s tha	2	HYPE	276	= 70 516	ON							
Records,	v requiras that the daath cer been signed by the attandin should be datached for use	8	HYPE	2011	AD 7	FOI	7)	SEAC	<i>/=</i> -		an autopsy	24b. Wer avai	e autopsy findings lable prior to
ည္မ	3 00	Completed	CURUNI	7129	PTICI	0109		J E 74 3				com	pletion of cause eath?
E .	The law ate has b page 2 s	5								101	rue 20Nu	10	Yes 2□ No
/ita	sician: The law certificate has t lirector, page 2 s	Re	25. Was case referred to me examiner?	-					WIN-S	ath (Check only o			
of Vital	Physician: this certific ral director,	0	1 ☐ Yes 2 No	۱			ER/Outpatient	3 DOA		lome 5 Resid			3
Ē	Ing P	ë	27. Manner of Death 1 Natural 5 □ Pe	ending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. fnju Wo		28d. Describe I	now injury occur	red	
Sic	Attending or death.	Cat	3 ☐ Suicide 6 ☐ Co	estigation ould not be	ngo Dioco e	f laium. At ha	and form atta]Yes 2□No	29f Location /	Street and Numb	ar or Bural	Pouts Mumber
Division	or At after of Direct in by	֡֓֞֡֓֡֓֡֡֡֡֡֡֡֡	4 ☐ Homicide de	termined		, etc. (Specif)		et, factory, office		City or Tox	vn, State)	er or Hurar	Houle Number,
_	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical Certification:	29a, Certifier 1 Cert	ifvina Phys	sician: To the be	est of my know	wledge, death	occurred at the t	ime, date and place	and due to the	cause(s) and ma	nner as sta	ted
	Horn Fur letely	<u>ğ</u>				is of examinat			opinion, death occu				
	withir To th	2	29b. Signature end title of ce	rtifier				29c. Licen	se number		29d. Date signe	d (Month, D	ay, Year)
			> V/4/1-3	Da.	Jula	I M	cm cm	D 73	33905		any 2	L, Z	204
		-	30. Name and eduless of per	son who co	ompleted cause	of death (Item	23a) (Type, f						
		- 1	111000	1 2	1	10 -		11-14	TAIR	4175K)	1 17 21 10	1 216	7 6 5 7 4 7 7
			VIV2 GINIA +	4. Dr	MANE	aistrar's Signa	CMD	101001	2018 2	1,00	(1-0) NH	aur	81022018

DHMH 16 Rev 6/95

			For State Registrar	State of	Marylan		artment rtificate				lental Hy	giene Reg. No. []	04	25296
	Dhysisi	an	1. Decedent's Name (First, Midd								2. Date of De Month	ath Day	Year	3. Time of Death
1	Physici /Medic		JOHN			ARD					JULY	20	5000	
1	Examin	er	4a. Facility Name (If not institute			Ans		「own, or レッハ	Location	of Death			nty of Deat	
			HOWARD CON 5. Social Security Number		7. Age (In yrs.		If Under		If Under	24 Hrs.	8 Date of Bir	1	O Rin	
	Funeral Director		577-46-5580	1⊠M 2□F	70	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 3/5/19	y, Year)	Wash	hplace (State or Foreign nuntry) nington DC
			Usual Residence of Decedent				1							80011 100
	nylan how	_	10a. State 10b. Count	•	10c. Cit	y, Town or Lo								10d. Inside City Limits
	8a-1 9	cto		ce Georges		Colle	ege Pa							1XYes 2 No
	vith th	Funeral Directo	10e. Street and Number	_			10f. Zip					10g. Citizen	of What Co	ountry?
	s 23s	graf	4706 Drexel Ro	12. Was Dece	dont Suor in II	C 12		740	ispanic Ori	igin? (Sp	acity Vac or No	14 F	USA	nican Indian,
	iter de l'Item	Ē	11. Marital Status 1 □ Never Married 2 ☑ Ma	Armed Fore	ces?						ecify Yes or No Rican, etc.)	E	Black, White	
036	urs a	2	3 ☐ Widowed 4 ☐ Divorce	If Vas Give	tes:		1 ☐ Yes 2	No.	Specity:			Spe	cify: Wh	nite
5-0	filed within 72 hours after death with the Maryland Hygiene. uther than "naturel", or Items 23a or 28a-f show ont, the Medical Exercitivations the notified at	Completed		ent's Education lest grade completed)		(Give	dent's Usua kind of wor	k done d	durina mos	t of work	ina	16b. Kind o	f Business/	Industry
7	ithin ne.	mpigu	Elementary/Secondary (0-12)		4or 5+)	life.	<i>DO NOT</i> us inical	e retireo	1)		3			
12	iled w lygiei ther ti		17. Father's Name (First, Middle	J (201)		Mecha	micai	. E11§			e (First, Middle			Government
and	ould be f Mental I arked of	Be	John Stockard								Walcot		iamoj	
Maryland 21215-0036	and Mental Hygiene. is marked other than aumatic event, the Ma	ပ္	19a. Informant's Name/Relation			19b. Maili	ng Address	(Street a			Walcot al Route Numb		wn, State, 2	Zip Code)
	nd 2 : alth ar 27 is r trau		Barbara Stocka	rd - Wife		1					lege Pa			
Je,	is 1 an of Heal item 2 other		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	(م	[Date	20c. Locatio	on - City or	Town, State
Ë	Page nent c int: If		¥☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (For For	t Linc	oln C	emet	ery	7/2	6/2004	Bren	twood	, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Exactions Instrument be notified at QDCs.		21. Signature of Funeral Service Myslin T.	. Wobest				Blac	lensb	ro. [_urg	rt Linc Rd; Bre	ntwood		
	Pnysician /Medical		23a. Part1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	st only one cause on ea	ich line.	ORGAN				cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Examiner			Due to (d	or as a conseq	(Lence of):	riRA	HOS	(5	1 10	IEN			
		ē	Sequentially list conditions, if any, leading to immediate	b. DECOS Due to fe	or as a our sec	puarita of):								
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o. SE	PSIS									
o,	an ar	EX	resulting in death) Last	Due to (d	or as a conseq									
68760,	icate be executed physician and s the burial-transit	licai		d. ELEC	CTROCTI	'E ,,	9/3/41/	ANCO	-5					
P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nth 2 ☐ Feta ant at time of c	al death 3	⊒Ectopic pre □ Other (spe						Date of del Month	ivery Day Year
	that the	by Ph	Part II. Other significant condi	tions contributing to de	ath but not res	sulting in the u	nderlying ca	ause giv	en in Part I		23e. Did t	obacco use c	ontribute to	the cause of death?
rds	quires n sign	d b	ALCOHOL A		HISTS	27					1 🗆	Yes 2□No	3 🗆 Pr	obably 4 Unknown
Records,	aw requir s been si 2 should i	Completed	ANEMIA								24a. Was			itopsy findings available
R	eician: The faw certificate has t irector, page 2 s	mo	SPONTAN FOUS	BACTERIA	L PE	RITON	1715					rmed?	death?	completion of cause of
ita	ian: artifica ctor, J	Bec	25. Was case referred to medic examiner?								Check only	one)		
5	hyeic his ce	2	1 ☐ Yes 3 ☑ No	and the same of th	patient 2			A Oth	er: 4 □ Nu		me 5 🗆 Resi			cify)
n o	ft e		27. Manner of Death 1. ☑Natural 5 ☐ Pend	aling .	of Injury h, Day Year)	28b. Time o Injury		8c. Injun Worl			28d. Describe	how injury oc	curred	
Sio	Attending or death. ector: After by the fune	cati	3 ☐ Suicide 6 ☐ Coul		of Injune At h	ome form st	M		Yes 2□		28f Location /	Street and Nu	imbor or Di	ural Route Number,
Division of Vital	I or Attendi after death. Director: A I in by the fu	ertif	4 Homicide dete	mined 286. Place buildin	of Injury - At h ng, etc. <i>(Specil</i>	fy)	reet, ractory	, OTTICE			City or To		IIIDBI OI AC	arar nobie ivaniber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;		ying Physician: To the al Examiner: On the ba and mann	sis of examina									
	To th within To th	Me	29b. Signature and title of certif	ier			29c	. Licens	e number	_		29d. Date sig	gned (Monti	h, Day, Year)
	_		> peld	ATTENDIN	4 PHY	18161AN	1	00	5694	18		JULY	21	2004
2	(10)		30. Name and address of person	SINDA 8	775 ci	LOVDLEA	r cs	vas	col	UNB	A. MO	5104	5	
	Sta Regist		31. Date filed (Month, Day, Yea JUL 2 2	2004 36 Re	egistrar's Signa	ature .	where							

ורוג	D SOUDE	1100	State of Maryland / Department of Healt		ental Hyg	giene			
			1 - Stata Registrar Certificate of Deal 1. Decedent's Name (First, Middle, Last)			leg. No:] 4	252	97
	Physici			'	2. Date of Dea Month	Day	Year	3. Time of	М
da	/Medic Examin			ation of Death	JULY	29 , 200 4c. County		<u> 1727</u>	_ P ""
	ZX		PRINCE GEORGES HOSPITAL CENTER CHEVERLY				NCE (SEORGES	3
-9%	Funeral		F70 / 2 (F10) Months Days Hou	Jnder 24 Hrs. purs Min.	B. Date of Birth (Month, Day eb. 18	Year)		place (State o	
	Director		Usual Residence of Decedent	1	eb. 18	,1934	wasn	ington	DC
	nyland how		10a. State 10b. County 10c. City, Town or Location				1	IOd. Inside C	
	8e-f s	Director	Maryland St. Mary's Ridge					1 🗌 Yes	2/1 No
	h with th	al Dire	10e. Street and Number 50380 Bay Avenue P0 Box 449			U.S.A.	Whal Cou	ntry?	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23e or 28e-f show any injury or other treumatic event, the Medical Eventral remail be routiled at once.	by Funeral I	3 Widowed 4 Divorced If Yes, Give 1 Yes 2 L2**N6 Spe	nic Origin? (Spec exican, Puerto R pecity:	ify Yes or No- ican, etc.)		ck, White,	can Indian, etc. ite	
5 O	72 hc	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during	g most of working	9	16b. Kind of Bi	usiness/In	dustry	
121	within ane. than	Completed	1 Sementary/Secondary (0-12) College (1-4or 5+) Iffe. DO NOT use retired) Air Conditionin	· ·		Self-em	ıp1ov	ed	
	Hygid other ent,	Be Co	17. Father's Name (First, Middle, Last) 18. N	Mother's Name (
/lan	Menta Menta arked artic ev	To B	William I. Souders	Susan	E. Ba	iley			
Maryland	ind 2 sho alth and I 27 is ma er treume		19a. Informant's Name/Relationship (<i>Type, Print</i>) Jackie Lott (Daughter) 19b. Mailing Address (<i>Street and No.</i> 51 Margaret Ct	v ^{umber of Rural} t. Charl	Route Number es Tow	n, City or Town n, W. V	State Zig A 252	14°	
altimore,	Pages 1 and nent of He ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemete	Aug.Da	6, 004	20c. Location - Clint		own, Siate Mary1ai	nd
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licensee 22. Name and Address of F			eral Ho Road C			20735
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ch as cardiac or	respiratory arr	est,		Approximate Interval Bette Onset and I	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	5 w	I con	Picato	ones	Oriset and t	Death
В	Examiner		Due to (of as a consequence of):			•			
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying				_		
	licate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):						
8760,	be exician buriat								
687	ificate g phys	edical							
.O. Box	The law requires that the death certific lie has been signed by the attending pi page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Dat	te of delive	,	'ear
Δ.	es that (igned b)	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.	23e. Did tol	bacco use conti	ribute to th	ne cause of d	eath?
Records,	w requires been sign should be				1 □ Y	es 2 No	3 🗆 Prob	ably 4 🗀 U	inknown
ecc	ne taw re has be ge 2 sh	Completed			24a. Was a	n 24b. \	Nere auto	psy findings a	available ause of
<u>=</u>		Con			Yes 2	med? 2□No	leath? Yes	2□ No	
Viia	ysician: This certificate	o Be	examiner?	Place of Death (\	-	
ō	Attending Physician: It death. ector: After this certificiby the funeral director.	Η,	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	☐ Nursing Home		ow injury occurr		/ /	_
Division of	Attendin death. ctor: Aft y the fun	Certification:	2 Accident investigation 7/2/64 // 34 M 1 Yes	2/2 No 5	uspert	fello	min	-lodo	len
Š	l or Attendente efter death Director:	rtific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place 1 Injury - At home, farm, street, factory, office building, etc. (Spedfy)	28	If. Location (St City or Town	reet and Numb n, State)	er or Rura	I Route Numi	ber,
	Hospitel or A 24 hours effer Funerel Dire etely filled in by		29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, dat	ate and place, an	7 S	71-31	, /	E-	
	To the Hospitel or At within 24 hours effer of To the Funerel Directompletely filled in by	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	n, death occurred	d at the time, d	ate and place	and due to	The cause()	
	To the To the comp	ğ	29b. Signature and title of certifier 29c. License numb O. C.M.		2	9d. Date signed	d (Month,	Day, Year)	
			() Carteful	.1. Li				2004	
. 1	0+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	D-1+4		.12.0	1001		
	Sta	- 1	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltimor	re, Mar	yland 2	1201		
	Registr	ar "	AUG 1 0 2004 Some & Sparks						

State of Maryland / Department of Health and Mental Hygiene

8 11 104 1H
Certificate of Death

Reg. NG State Registrament ITEM #4a PER PHY G834 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Yeer **Physician** Ju1y 7, 2004 2:10AM ELIZABETH ANN TRADER /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner 4a. Fecility Name (If not instit 8620 MEMORY GARDEN LANE Wicomico

9. Birthplace (State or Foreign Country) Hebron
If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days **Funeral** Hours 1□M 2□F Director 69 12/23/34 214-32-2085 Gumbora, De Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Maurical Examples in the intillical at once. 10a. State 10b. County 1 ☐ Yes 2 ☐ No Md Wicomico Hebron 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number America
14. Race - American Indian,
Black, White, etc. 8620 Memory Garden Lane 21830 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3€ Midowed 4 Divorced No White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) POultry 1.2 Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 01over 2 Lillian A. Timmans H. Gray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 Heartwood Dr. Salisbuty Md 21804 to of Disposition (Name of Date 20c. Tanton - City or Town, State Shelia Bradford, Daughter 119 Heartwo lethod of Disposition 20th Place of Disposition (Name of completely, crematory or other place) Baltimore. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Hebron Cemetery 7/10/04 Hebron Md 22. Name and Address of Facility
Messick Funeral Home, P.O. Box, Bivalve 21. Signature of Juneral Service Licensee M00 - 417Sinders Mossich Maryland 21814 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner The law requires that the death certificate be executed **burial-transit**)a 1 0 Due to (or as a consequence of): Box 68760, To Be Completed by Physician/Medical as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed/ 2₩No 2 🗆 No 25. Was case referred to medical examiner? 1 Yes Division of Vital 26. Place of Death (Check only one) Director: After this certific I in by the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑No 1 🗌 Inpatient 2 ER/Outpatient 3 🗆 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medicai Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours aft To the Funeral Di completely filled in Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 9 2004 Registrar

		•	State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and Martificate of Death		ene 1. No 2004 25299
			Registrar 1. Decedent's Name (First, Middle, Last)	Timoate of Death	2. Date of Death	
	Physicia	an			Month	Day Year
	/Medic		Sister Andrea Mac Varish	4h Chi Tara art artis (Bart	August	3, 2004 9:15 A. M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		
			St. Vincent Care Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Emmitsburg If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Frederick
	Funeral Director		215-54-2913 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day,) May 31,	9. Birthplace (State or Foreign Country) 1901 Canada
	and		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	f sho	ö	MD Frederick Emmitsb	urg		1 ∑ Yes 2 ☐ No
	death with the Maryland ms 23e or 28a-f show	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Country?
	with with	⊡	335 South Seton Avenue	21727		U.S.A.
	leath	era		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
_	r Iten	Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No		Rican, etc.)	Black, White, etc.
ğ	urs a	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 A No Specify:		Specify: White
215-0036	be filed within 72 hours after death with the Marylan death yyliene. Idely Hyliene. Idely Hien "natural", or liems 23e or 28e-f show are not the marker are not the marker are not the marker at the marker are not the marker a	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	10	6b. Kind of Business/Industry
2	hin 7	ple	(Specify only highest grade completed) (Give life.	kind of work done during most of work DO NOT use retired)	9	Religious Community
7	er th	0		of Aged and Infir		Daughters of Charity
2	be filed ntal Hygi od other event, I	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Surname)
<u>a</u>		5	George Mac Varish	Catheri	ne Mac E	achen
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip Code)
	를 5 를 달			S. Seton Ave., Em		
altimore,	es 1 ar of Hea fitem r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	osition (Name of matory or other place)	Date 20	Oc. Location - City or Town, State
Ĕ	permit. Pages Department of I Importent: If it eny injury or o			PH'S P.H. 8/5/0	4	EMMITSBURG, MD.21727
a	permit. Pag Department Importent: I eny injury c		21. Signatur Funeral Service Licensee	2. Name and Address of Facility	KILES FU	NERAL HOME
m	8 G E 2 G	(1)	In M. skiles	210 W. MAIN ST., H	EMMITSBUR	G, MD. 21727
	Physician /Medical Examiner	J6	23a. Part. Enter the disease, or complications that crused the death. Do not en shoot, or heart failure. List only one cause in each line. Immer is e Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Verture fel as cardiac of the mode of dying, such as cardiac of the mode of dying, such as cardiac of the mode of	ant for	Approximate Interval Between Onset and Death
68760,	ificate be executed g physician and as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.			7
.O. Box	Attending Physicien: The law requires that the death certificat robath. cator: After this certificate has been signed by the attending phy by the itneral director, page 2 should be detached for use as the	by Physiclan/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
Records, P	uires that n signed k Id be deta		Part II. Dther significant conditions contributing to death but not resulting in the C	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to the cause of death? : 2☑No 3☐Probably 4☐Unknown
ខ្ល	w req been shou	Completed	Carely al Dalayatis	1994	24a. Was an	24b. Were autopsy findings available
æ	he la e has ige 2	μŽ	Secret Fugure		autopsy	prior to completion of cause of death?
a	ification. T	ပိ	25. Was case referred to medical	26 Place of Death	1 Yes 2	
⋝	sicie cert irect	8	examiner? 1 Yes 2 🖾 No			ice 6 Other (Specify)
ō	Phy ar this aral o	۲: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how	
o	th. :: Afte	ig ig	1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division of Vital	Atter r dea ector by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number,
Ö	s afte	Certification:	4 Homicide Geleininied building, etc. (Specify)		Say or rown,	/
	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, deal (Check only one) 1 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ceriffer	29c. License number	290	d. Date signed (Month, Day, Year)
	P S P Ö) (XXx I MILALL)	V 1/1870	5 3	AUGUST 2004
•	V		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	<u> </u>	1.55551 2551
	1		ALAN CARROLL, M.D., 310 S. SETON A		71727 מ	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature		2 4 1 4 1	
	Regist	rar	AUG 1 1 2004 General &	South		

WCISh, DCNNiS Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

			For	State of Maryland / Dep #15 PER FH G834 &	artment of Health and	Mental Hygie	2001 25300
	Physici	an	1. Decedent's Name (First, Middle, Last)		THE DEALT	2. Date of Death	No. 9 4 2 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9
>	/Medic Examin		4a. Facility Name (If not institution, give	lann Welsh street and number)	4b. City, Town, or Location of Dea	oth July	4c. County of Death
	LAdmin	.	Easton Hospita		Easton		Taibot
	Funeral Director		5. Social Security Number 6. Septing 139–36–3794 Usual Residence of Decedent	7. Age (In yrs. last birthda) M 2 F Yrs.	/) If Under 1 Year If Under 24 Hr Months Days Hours Min	1. (Month, Day, Ye	9. Birthplace (State or Foreign Country) 6,1944 Pennsylvania
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the then "natural; or teems 23e or 28e-f show ent, the then "healest Eran and natural to notified along."		10a. State 10b. County	10c. City, Town or I	Location		10d. Inside City Limits
	8a-1 s	Director	Maryland Carolin	ne Dento			1√ Yes 2 No
	with the or 2		10e. Street and Number		10f. Zip Code		. Citizen of What Country?
	death	Funeral	415 Kerr Avenue	ADE. A 12. Was Decedent Ever in U.S. Armed Forces?	21629 . Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		ited States 14. Race - American Indian, Black, White, etc.
36	or Ite	by Fu	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 ☑ No Specify:	nto mican, etc.)	Specify:
21215-0036	thour	q pa	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates: cation 16a. Dec	edent's Usual Occupation	161	Caucasian b. Kind of Business/Industry
215	thin 72 e. en "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) (Giv	e kind of work done during most of w DO NOT use retired)	orking	,
121	iled wi tygien ther th	Con	12 17. Father's Name (First, Middle, Last)		Messenger	ame (First, Middle, Mai	ourier Service
lanc	id be f ental h ked ot ic eve	To Be	Richard Gilk	ert Welsh		Rebecca Man	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department if them 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other traumatic event, the Meulcal Evaluation into the invities at ponce.	-	19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or F		
Σ «	and 2 lealth m 27 I		M. Rebecca Welsh		ark Lane, Easton,	_	
Baltimore,	ages 1 nt of H :: If ite		20a. Method of Disposition 1 □Burial 2 □ Cremation 3 □ P	emovariioni State	position (Name of ematory or other place)		c. Location - City or Town, State
atin.	nit. Parame vartme cortent injury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sarvice Usens	A / 1 '		and the same of th	Denton, Maryland
ä	Dermi Depa Impo any ii		& Kandoffy	f. (Nour	Moore Funeral How 12 South Second S	e, P.A. Street Den	ton. Maryland 21629
	Pnysician /Medical		23a. Part1. Enter the disease of r complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not ele cause on each line. Alcoholic Liverage. Due to (or as a consequence of):	nter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Batween Onset and Death
	Examiner	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	uted 1 Insit	Examiner	Cause (Disease or injury	Due to (or as a consequence or).			
,092	Ite be exacuted lysician and he burial-transit	cal Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):			
89	rtificat ng phy as the	Medic	ic comme			*)	
.O. Box	The law requires that the death certificate the has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
٥	iires that signed b	by P	Part II. Other significant conditions cor	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
ord	w require been sig should b					1 🗆 Yes	2 No 3 Probably 4 Onknown
Vital Records,		Completed				24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	lospital:	Other	eath (Check only one)	
of	g Phys er this eral di	\vdash	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	Home 5 Residence 28d. Describe how i	e 6 ☐Other (Specify) injury occurred
sion	Attending Ph r death. actor: After th by the funeral	atlo	Natural 5 Pending investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
	ac ac by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		City or Town, S	
	To the Hospitel or within 24 hours after To the Funarel Dir completely filled in	Medical	one)	sician: To the best of my knowledge, deaner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occurred.	curred at the time, date	and place, and due to the cause(s)
)	To To con	2	29b. Signature and title of certifier		29c. License number D 00538/5	29d.	Date signed (Month, Day, Year) $\frac{7}{2} \frac{7}{2} \frac{2}{2} \frac{0}{2} \frac{\sqrt{2}}{2}$
<				mpleted cause of death (Item 23a) (Type	,	_	
	Sta Registr	- 1	31. Date filed (Month, Day, Year) JUL 2 8 2	D. 912 Market Stre 32. Registrar's Signature	et, Denton, Maryl	and 21629	
	- riegioti		001 2 0 2	THE LOT	43034(1)		

100		For State Registrar AMFND ITEM # 1. Decedent's Name (First, Middle, Last)					2	Date of Dear	th Day	Year	3. Time of Death
Physicia /Medica		Ira Edward Wal	tz					July_	17	2004	1:30 P
Examine		4a. Facility Name (If not institution, give s				wn, or Location	of Death			ounty of Death	
· · · · · · · · · · · · · · · · · · ·		22830 Federal Lool		a urc last hirthday		hsburg	er 24 Hrs. 8	Date of Birth		shingto	
Funeral Director		5. Social Security Number 6. Sex 220−10−3451 Usual Residence of Decedent	M 2□F	n yrs. last birthday, 89 Yrs.		ays Hours	Min.	Date of Birth (Month, Day)	, Ye <i>ar)</i> 1915		place (State or Foreig intry) 7 Land
s late		10a. State 10b. County Maryland Washingto	1	oc. City, Town or L Smith	ocation Isburg						10d. Inside City Limit:
Hygiene. wher then "natural", or Items 23a or 28e-f show ent, the Medical Examination matthes at	Director	10e. Street and Number			10f. Žip Co	ode		1	0g. Citize	en of What Cou	intry?
3a or		22830 Federal Loo	kout Road		217	83				U.S.A	A.
ms 2	Funerai		2. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Deceden If Yes, specify		Origin? (Speci	fy Yes or No-	14	4. Race - Amer Black, White	ican Indian,
al', or Ita	by	1 Never Married 2X Married 3 Widowed 4 Divorced	1X Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2X				S		nite
n "natur Aedical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed) College (1-4or 5+)	(Givi	edent's Usual C kind of work of DO NOT use i	done during m	ost of working		16b. Kind	d of Business/l	ndustry
e de la composición della composición della comp	E O	11	College (1-401 5+)	Ca	arpente					tructio	on
othe vent,	Bec	17. Father's Name (First, Middle, Last)						First, Middle,		Sumame)	
rked fic e	ToE	Ira H. Waltz						E. Lew			
and s		19a. Informant's Name/Relationship (Type	oe, Print)							Town, State, Z	2170
n 27 I		Audrey S. Waltz			330 Fed						Maryland
i iter		20a. Method of Disposition	emoval from State	20b. Place of Disp cemetery, cre	osition (Name ematory or othe	or place)	Dat			ation - City or T	
ant		* 4 □Donation 5 □ Other (Specify)		Smithsb							rg Marylan
Depenment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinet read he notified at once.		21. Signature of Funeral Service License	Line								eral Home cyland 217
		23a. Part1. Enter the disease, or compli- shock, or hear ailure. List only on	cations that caused the	e death. Do not er	nter the mode o	of dying, such	as cardiac or	respiratory arr	est,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition		heiners	Dis	ease					Onset and Death
edical		resulting in death)	Due to (or as a c		<i></i>	2015-6					2 9 - 4. 5
miner		Sequentially list conditions).								
#	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	ionsequanna oty:							
tran	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):						-	
ysicien and e burial-transit	ai E		223 13 (3. 23 2 3								
physi the l			1								
attending physi I for use as the I	Physician/Medic	IF FEMALE: 2	3c. If yes, outcome of	pregnancy					23	3d. Date of deli	very
atten for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 (4 ☐ Pregnant at tir		□Ectopic preg □ Other (spec					Month	Day Year
	ysi	9 Unknown	9□ Unknown								- ar to see
ched	2	Part II. Other significant conditions cor	ntributing to death but i	not resulting in the	underlying cau	se given in Pa	πI.	23e. Did to	bacco us	se contribute to	the cause of death?
ached	>							1 🗆 Y	es 2 🖔	}No 3∏Pro	obably 4 Unknov
gned by the se detached	d by							24a. Was a		24b. Were au	topsy findings availat
been signed by the should be detached								perfor	med?	death?	2□ No
has been signed by the je 2 should be detached											
ite has been signed by the page 2 should be detached	Completed	25. Was case referred to medical				26. PI	ace of Death	Check only o	ne)		
ite has been signed by the page 2 should be detached	Be Completed	examiner?	Hospital: ↑ ☐ Inpatient	z SER/Outpati	ent 3□ DOA	Other		Check only o		□Other (Spec	city)
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neral director, page 2 should be detached	To Be Completed	examiner? 1 Yes 2 No F 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y			Other	Nursing Hom 28	Check only of	ence 6		ify)
lter this certificate has been signed by the neral director, page 2 should be detached	ertification: To Be Completed	examiner? 1 Yes 25 No F 27. Manner of Death 1 Natural 5 Pending	1 L Inpatient	/ear) 28b. Time Injury	of 28d	Other: 4 Conjury at Work?	Nursing Hom 28	Check only of eside	ence 6 ow injury	occurred Number or Ru	ral Route Number,
lter this certificate has been signed by the neral director, page 2 should be detached	Certification: To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 No 1 Yes 2 No 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: To the best of ner: On the basis of e	28b. Time Injury At home, farm, s (Specify) my knowledge, dexamination and/or	M 280 street, factory, of ath occurred at	Other: 4 c. Injury at Work? 1 Yes 2 office	Nursing Hom 28 No 28 and place, ar	e esid de Describe h	ence 6 ow injury Street and m, State)	occurred Number or Ru and manner as	ral Route Number,
tier this certificate has been signed by the neral director, page 2 should be detached	ertification: To Be Completed	examiner? 1 Yes 25 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a, Certifier Certifying Phy	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	28b. Time Injury At home, farm, s (Specify) my knowledge, dexamination and/or	M 280 M itreet, factory, of ath occurred at investigation, in	Other: 4 c. Injury at Work? 1 Yes 2 office	Nursing Hom 28 No 28 and place, ardeath occurred	e e e esid ad. Describe h as. Location (S City or Tow and due to the of d at the time, of	ience 6 ow injury Street and m, State) cause(s) a date and	occurred Number or Ru and manner as	ral Route Number, stated. to the cause(s)
tter this certificate has been signed by the neral director, page 2 should be detached	edical Certification; To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: To the best of ner: On the basis of e	28b. Time Injury At home, farm, s (Specify) my knowledge, dexamination and/or	M 280 M itreet, factory, of ath occurred at investigation, in	Other: 4 Injury at Work? 1 Yes 2 office	Nursing Hom 28 No 28 and place, ardeath occurred	e e e esid ad. Describe h as. Location (S City or Tow and due to the of d at the time, of	ience 6 ow injury Street and m, State) cause(s) a date and	occurred Number or Ru and manner as place, and due	ral Route Number, stated. to the cause(s)
ite has been signed by the page 2 should be detached	edical Certification; To Be Completed	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier (Check only one) Construction (Check only one) Construction (Check only one)	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. sician: To the best of ner: On the basis of e and manner state	(ear) 28b. Time Injury (- At home, farm, s (Specify) my knowledge, de. xamination and/or d.	M 28c M 28c	Other: 4 Injury at Work? 1 Yes 2 office	Nursing Hom 28 No 28 and place, ardeath occurred	e e e esid ad. Describe h as. Location (S City or Tow and due to the of d at the time, of	ience 6 ow injury Street and m, State) cause(s) a date and	occurred Number or Ru and manner as place, and due	ral Route Number, stated. to the cause(s)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death S. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** July 25, 2004 5:55 P Wattenford Mary Rose - /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charles 5148 Dorchester Circle Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 11, 1943 Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 ☐ M 2 💢 F Yrs. 60 Director 177-34-2311 Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10b. County ral', or Items 23a or 28a-f show Examiner is ust be notified at 1 ☐ Yes 2√ No Completed by Funeral Director MD Charles Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5148 Dorchester Circle 20603 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural', or 1 ☐ Yes 2 🌠 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 Senior Sales Associate Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hisant: If item 27 Is marked oth Mary Rose George Edward Gerard Bergin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mylo Wattenford - Husband 5148 Dorchester Circle, Waldorf, MD 20603 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 07-29-2004 <u>Cheltenham, MD</u> 22. Name and Address of Facility
Huntt Funeral Home
3035 old Washington Rd., Waldorf, MD 21. Signature of Funeral Service Licenses M01246 William Nack 20604 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Weast Priysician metarlati 10 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ this funeral 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 \ Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1)46246 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aldorf 31. Date filed (Month. State Registrar

DHMH 17 Rev 1/2001

04-04992-033

Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of D	eath 7/31/0	4 3. Time of Dea
/Medic		James Anthony Woodland	Auc	. 01.200	211
Examin	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of E		4c. Count	
	c	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24	IGHT Hrs. 8. Date of 8		INCE GEORGE
Funeral Director			Min. (Month, D	ay, Year)	Birthplace (State or Fo Country)
		Usual Residence of Decedent	Jan. 2	7, 1944	Maryland
t at	_	10a. State 10b. County 10c. City, Town or Location		-	10d. Inside City Li
Ba-f s	Director	Maryland Prince George's Capitol Heights			1 ∑ Yes 2 [
Lor 2	Dire	10e. Street and Number		10g. Citizen of	What Country?
18 236	Funerai	4 Vale Place 20743 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	2 (Cassily Vesses N		ed States
item	-un	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 12. Marned Forces? 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	uerto Rican, etc.)	Bla	ce - American Indian, ick, White, etc.
el', ol	ρ	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specif	y: Black
lical	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of	· working	16b. Kind of B	Business/Industry
n and Mental Hyglene. 7 Is marked other than " raumatic event, It e Mar	npie	Elementary/Secondary (0-12) College (1-4or 5+)	WOIKING		
her t		10th Carpenter			Private
i neam an water rygelie. Item 27 is marked other than "naturel", or liems 23a or 28a-f show other traumatic event, Ira Madical Examinar must be notified at	Be		Name (First, Middle		,
narke	၉	Thomas Andrew Woodland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			beth Barnes
7 Is r		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Street and Number of		-	
tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of	Date		- City or Town, State
Department of Health a Important: If item 27 Is any injury or other traitonce.		1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	17 12001		
ortan injur e.	li	^ 4 □ Donation 5 □ Other (Specify) Harmony Memorial Park 8, 21. Signature of Funeral Service License 22. Name and Address of Facility			over, MD
Impo any ir	5 9	John I. Shuran III 4001 Benning Ro			
		23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.			Approximate Interval Between
hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter U deriving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			0
igned by the attending phy: be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown			ate of delivery onth Day Year
been signed should be de	ed by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use cont	tribute to the cause of death 3 Probably 4 Unkr
2 2	Completed		24a. Was auto perf	psy	Were autopsy findings available to completion of cause death
certificate rector, pag	Be	examiner?	Death Check onl		
this ral dir	٦.	AA 163 2 NO 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursin			ner (Specify)AT SCEN
After funera	tion	1 XNatural 5 Pending (Month, Day Year) Injury Work?	200. Describe	how injury occur	rea
Director: A	fica	2 Suiside 6 Could not be	28f. Location	Street and Numb	per or Rural Route Number
Dire Dire d in b	Certification;	4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or To	wn, State)	
within 24 thous after to beaut. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p 2 wedical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the occurred at the time.	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
To th	M	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)
00		Mullime The Shill M O.C.M.E.		AUG.0	1,2004
MC		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
Je.		MANUAL DESCRIPTION OF LORGE 111 Penn Street, Balt			

			For State Ragistrar	State of	r Marylan		artment of H <i>rtificate of I</i>		and M		giene Rag. No. ()		25304	
			Decedent's Name (First, Middle, I	Last)					-	2. Date of De.	ath		3. Time of Death	
	Physicia			Maude	Lorene	e Herr	on Young			Month July	Day 24	Year 2004	8:30p M	A
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City, Town, or	r Location o	of Death	0427		inty of Death	, 0.30p	_
Н			26609 Haney Ave	nue			Dam	ascus	3			Montg	omerv	
	Funeral			. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under a		8. Date of Birt (Month, Da	h v. Year)	9. Birthp	place (State or Foreig htry)	ın
	Director		178-09-2456	1□M 2ØF	89	Yrs.	Months Bays	1100.5		Dec. 1		Penn	sylvania	
	and W		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						I Od. Inside City Limits	
	f sho	ö											1 ☐ Yes 2 🖾 No	
	28a-	ect	Maryland Montgo	omery	Dama	iscus	10f. Zip Code				10g Citizen	of What Cour	ntry?	
	with 3a or	Funeral Directo	26609 Haney Aven					0070					•	
	Jeath The 2:	era	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of H If Yes, specify Cuba	10872 Iispanic Orig	gin? (Spe	cify Yes or No		d State		_
(0	r iter	Fur	1 Never Married 2 Married		2 (XNo				i, Puerto	Rican, etc.)		Black, White,	etc.	
ĕ	al', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or Da	re ates:		1 ☐ Yes 2 🕱 No	Specify:			Spi	ecify: Wh:	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or Items 23a or 28a-f show ant, Ite Madical Examinar must be notified at	Completed	15. Decedent's (Specify only highest			16a. Dece	dent's Usual Occup	ation	t of worki	20	16b. Kind o	f Business/In	dustry	_
2	ithin	nple	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	d) -		.g				
2	ed wygien ygien aar th	S		1]	Beauticia					ty Sale	on	
nd	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, La	ast)				18. Mothe	r's Name	(First, Middle,	Maiden Sur	name)		
yla	should ind Men s marke umatic	ပ	Robert Walker He							Jenkins	•			
Maryland	2 sh and Is m		19a. Informant's Name/Relationship				ng Address (Street							
	1 and Health tem 27 other tr		Mildred Winkler, 20a. Method of Disposition	/_Sister_	20h P	26609	9 Haney A	venue	.Dam	ascus,_	Maryla	and 20	372	_
ō	Pages nent of h int: if ite		1 X Burial 2 ☐ Cremation 3		State	emetery, crei	matory or other plac					,		
ţ	t. Partmentant		`4 □Donation 5 □Other (Spe		Gat	te of	Heaven Ce	emeter	y 7/	30/04	Silve	r Spri	ng, Maryla	an
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "naturat", or items 23a or 28a-f show any injury or othar traumatic event, it a Madical Examinat must be notified at Once.		21. Signature of Juneral Service Lie	censee		Q.	2. Name and Addres lin L. Mo 5401 Ridg	leswo	rth	P. A. F	unera:	l Home		
	40200	- 10	23a. Part1. Enter the disease, or co	Wyc		26	6401 Ridg	e Roa	d, D	amascus	, Mary	land 2		
L.			shock, or heart failure. List or	nly one cause on e	ach line.	1. Do not en	ter the mode or dyin	ig, such as	A a	r respiratory at	SI,	1 -	Approximate Interval Between Onset and Death	
4	Pnysician	i n	Immediate Cause (Final disease or condition		V - 1 1							36		
	Madical		resulting in death)	a	u	e	myoca	are	lea	ring	are	non	1 hour)
	/Medical Examiner		resulting in death)	aDue to ((or as a consequ	uence of):	myoci	are	Lee	ring	are	tion)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 9^{Pay} 2004^{ear} 3:00 P M AWNER LEON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE BALTIMORE MILFORD MANOR NURSING HOME If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) JULY 15,1914 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Months Yrs. Director 212-18-8674 90 POLAND Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 3011 FALLSTAFF ROAD #207-A Itams 23a 21209 USA Completed by Funeral 12. Was Decedent Ever in U.S.
Amed Forces?
1 X1Yes 2 □ No WWI Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 🎇 No WHITE Specify. 3 X Widowed 4 □ Divorced "natural" 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) al Hygiene. College (1-4or 5+) **PROPRIETOR** SCRAP METAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental **AWNER** SAMUEL SARAH PAPIFR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 MIMI GETLAN / NIECE 6802 WELLWOOD COURT - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW FRIENDSHIP CEM 8/11/2004 [^] 4 □ Donation 5 □ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign kyre of Funeral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Impediate Cause (Final a end-stage Alzheimers **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Opisease or injury that initiated events Due to (or as a sonsequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregunt 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 \ No 1 Yes 2 🗐 1 TYes 25. Was case referred to 26. Place examiner' Other: Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) f Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) sajapahreno 57 465 8/10/04

State Registrar

31. Date filed (Month, Day, Year)

N.S. Rajapakse, M.D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajupakse, M.D. 25 Main St., Suite 200 - Rois territown, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** MARY ANNE BODENBURG 7:55 04 2004 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARINER HEALTH OF FOREST HILL HARFORD FOREST HILL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year Jan 27, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🖸 F 219-01-7348 96 Yrs Director Delaware Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10h Counts 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner, was be natified at MD Harford Forest Hill Director 1 ☐ Yes 2√∑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forrest Valley Drive 21050 Pages 1 and 2 should be filed within 72 hours atter death vent of Heatth and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23ary or other traumatic event, It a Modical Examited in the Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) assembly person western electric unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Wallace James Shockley Emma May Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2601 Green Road Baldwin, MD Alice Houck/friend 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 1 4 ☑ Donation 5 ☐ Other (Specify) Synular Funeral Service Licensee Ronald S W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 neur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss or Injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certiticate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. use as IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 rmea? 2 **∆**No 1 Yes Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Atter Natural Injury 5 Pending after death. Diractor: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide tilled in 24 hours a 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P32255 20005 TY 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID S. DUNN 615 W. MacPHAIL ROAD, BEL AIR, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1 () John Joseph Baldwin August 2004 4:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth 7963 Oak Road Pasadena Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | NOV 13 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1936 1X)M 2□F 213-36-2453 67 Usuel Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pasadena Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21122 7963 Oak Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1960-1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 1962 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Insurance Analyst Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Baldwin Lillian Conway ٧. <u>Joseph</u> 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7963 Oak Road, Pasadena, MD 21122 Linda A. Baldwin (spouse) Date 11 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 1 Burial 2 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) Metro Crematory Inc. 2004 Baltimore, Maryland Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part1. Enter the dise e.e., or complic shock, or heart failure. List only on that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause or each line. Approximate Interval Between Onset and Death or complication Immediate Cause (Final disease or condition resulting in death) 4 mos MO Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) TOYES 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

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Baltimore, Maryland 21215-0036 permit. Pages Department of Important; If It any injury or o 21. Signature of Funeral Service Licen **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE 23b. Was decedent pregnant ō signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed has page 2 certificate 25. Was case referred to medical Be 2 After this 27. Mannerof Death Certification: Director: / within 24 hours a To the Funeral E Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 3001 oung 31. Date filed (Month, Day, 1 32. Registrar's Signature State 2004 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Physician

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ပ်	aw as b	ompieted									24a. Was autop	sy	prior to	o compl	findings available etion of cause of
<u> </u>	Th ate pag	O									perfor	2 No	death? 1 ☐ Ye		□ No
VII		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		50/0 :		Other	r		(Check only or				
Ö	g Phys er this eral di	Ha	27. Manner of Death	1 Inpat 28a. ate of In	jury	ER/Outpatien 28b. Time of		Sc. Injury Work'	4 11401		ne 5 🗌 Resid 28d. Describe h			ecify)	
0	Attending F r death, ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 Accident investigation	(Month, D	ay Year)	Injury	М		? 'es 2 □ N	No					
IVISION	r Attender death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In	njury - At ho	me, farm, str	eet, factory,	office		1	28f. Location (S City or Tow	itreet and	d Number or i	Pural Po	oute Number,
	oltel or ars afte rel Dire														
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the bes iner: On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred a restigation,	it the time in my opi	e, date and inion, deat	d place, a th occurre	and due to the o ad at the time, o	ause(s) date and	and manner : place, and di	as state ue to the	d. e cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and marrier s	nuiou.		29c.	License	number			29d. Dat	a, signed (Moi	nth, Day	v, Year)
	n.		1 Polent 9	222	M	\mathcal{D}_{-}		89	54	[]		8	18/0	4	
	"		30. Name and address of person who	ompleted cause of	death (Item	23a) (Type,	Print))	0		0 11	0 1	1.0	1	
			KODERT CETO	1/10/02	40	nur	yan	W	0761	rek	LL H	150	tall		
i.	Sta Registr		31. Date filed (ANGA) 200	4 32 99015	trar's Signat	ure 6	Apa	care				/			

Clyde Beyner 04-05055 MAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl

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	Call C	Registrar Decedent's Name (First, Mic					uncau	e or L	Jeani		2. Date of De			72309
Physician											Month	Day	Year	3. Time of Death
/Medical		Clyde	Will			rer					Augus	t 04,		0852 A M
Examiner	4:	a. Facility Name (If not institut					4b. City,	Town, or	Location o	f Death			unty of Dea	
		Prince George	s Ho	spital	Center			ever				Pri		eorges
Funeral	5.	Social Security Number	6. Sex			last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da April	th v. Year)	9. Bir	thplace (State or Foreign ountry) est Virginia
Director		235-02-6658	'X-	M 2[]F	46	Yrs.		, .			April	2, 195	8 We	st Virginia
D *	_	suel Residence of Decedent 0a. State 10b. Cour			100 Ci	ity, Town or Lo	ention							Land to the On the or
anyla			•											10d. Inside City Limits
98 - M	_		ice G	eorge's	K	Riverda								1 □Yes 2 □ No
or 2	1	0e. Street and Number		_			10f. Zip					10g. Citizer	of What Co	ountry?
5-0036 72 hours after death with the Maryland natural; or Items 23s or 28e-f show slical Exactions must be rediffed at a tended by Furneral Director		5808 Rittenho	use	Street			2	0737				USA		
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after or it	2	1 Never Married 2 M		1 ☐ Yes 2 If Yes, Give			1 □ Yes		Specify:					
21215-0036 de within 72 hours ale gione. et than "natural; or than "natural; or the model of the completed by Formoleted by Form	5	3 ☐ Widowed 4 🖾 Divord	ed	Year or Dai	tes:		103	2 X.**	эрвену.			Sp	ecify:	White
21215-00 ed within 72 hot ygiene. Per than "naturalis, ILA Medical Et., ILA Medical Et.		15. Deced (Specify only hig	ent's Edu	cation completed)		16a. Dece	dent's Usua	al Occupa	ation	of worki	na	16b. Kind	of Business	/Industry
thin thin	1	Elementary/Secondary (0-12		College (1-	4or 5+)				during most		· 9			
21 Signal of wind wind wind wind wind wind wind wind	<u> </u>	12				Co	nstru	ctio	n Wor	ker		Const	ructi	on
be file that the svent		7. Father's Name (First, Midd	le, Last)						18. Mothe	r's Name	(First, Middle	Maiden Su	тате)	
Vlari		Bill Beyrer							Ar1	ene	Bever1	in		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If term 27 is marked other than "natural; or items 23a or 28e-f show any injury or other treumatic svent, Ite Medical Examination and once. To Re Completed by Funeral Director		9a. Informant's Name/Relation	nship (Ty	pe, Print)		19b. Mailie	ng Address	(Street a	and Numbe	r or Rura	/ Route Numb	er, City or To	own, State,	Zip Code)
Md 2 lith a 27 lith a ritre		Arlene Beverl	in -	Mother		580	8 Rit	tenh	ouse	St.	Riverd	ale. M	D 20	737
Baltimore, sermit. Pages 1 ar Department of Hea moortent: If Item nny injury or othe	2	0a. Method of Disposition			20b.									Town, State
ages nt of r:: If i		1 Burial 2 Crematic		emoval from S	tate Ce	Place of Dispo competery cray :nter P :urch C	oint°	Chri	stian	8/8/	04	Con	+ o = D	oint III
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Bal permi Depa Impo Impo any is	-	1. Signature of Funeral Servi	ce License	7	1001) 4	Harbe	rt F	s of Facility unera	1 Но	me			
20240	+	7 was	M	20010		\times	287 W	est :	Main_	St.	Salem,		Virgi	nia 26426
Physician /Medical	4	23a. Fart1! Enter the disease, shock, or heart failure. L mmediate Cause (Final disease or condition esulting in death)	ist only or	ne cause on ea	ch line.	ies wi					r respiratory a	rrest,		Approximate Interval Between Onset and Death
3760, ate be executed any sician end me burial-transit and in a Examiner	וכמו ורעם	Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last		Due to (o	or as a consec	quence of):								
Il Records, P.O. Box 68760, The law requires that the death certificate be executed as has been signed by the attending physician end page 2 should be detached for use as the burial-transit.	yalciai mac	FFEMALE: :3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2		th 2 ☐ Feta Int at time of t	aldeath 3[Ectopic pr					23d	. Date of de Month	livery Day Year
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w require the standard the should	ם ב										24- 146-			
Vital Rec	-										24a. Was			utopsy findings available completion of cause of
The cate has page	5										Yes		1/S Yes	2 □ No
Of Vital Physician: Titis certificate ral director, pa	2	5. Was case referred to med examiner?								of Death	(Check only o	nne)		
Of V Physic r this c		1 XYes 2 No		lospital: 1⊠In	patient 2	ER/Outpatier	nt 3□ DC	Othe	ar: 4 □ Nui	rsing Hor	ne 5□Resi	dence 6	Other (Spe	cify)
on of ding Physics After this funeral direction. To		7. Manner of Death 1 □Natural 5 □ Pen	dina	28a. Date of (Month	Injury Day Year)	28b. Time o	2	8c. Injury Work	at c?	P	assenge	how injury or	Motor	Vehicle
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Division c tel or Attending P rs after death. ed in by the tunera			ld not be imined	28e. Place o	of Injury - At h g, etc. (Speci	nome, farm, sti	eet, factory	, office		2	28f. Location (Street au 66	14er23	rd Rate Number,
s after so and in section in sect	5			Roadwa		.77					Hyatts	rille,	Md	,
Divisio To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the tu-		29a. Certifier 1☐ Certif (Check only 2 Madic one)	ying Phys al Exemi	sician: To the t ner: On the bas and manne	sis of examina	owledge, deat ation and/or in	n occurred vestigation,	at the tim , in my op	ne, date and pinion, deat	d place, a	and due to the ed at the time,	cause(s) and pla	d manner as	s stated. to the cause(s)
To th within To th comp		9b. Signature and title of cert	fier	de .			290	. License	number			29d. Date s	igned (Mont	h, Day, Year)
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	-	0. Name and address of pers	مادلات	moleted care-	of docth ff-	m 33a) (Turn-		0.0.	ri.E.			Augu	5L U3	, 2004
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- Cont	7	11. Date filed (Month, Day, Ye			gistrar's Sign	ature	TT LG	111 D	meet	, Ba	ltimor	e, Mar	yland	21201
State Registrar	+	ALIC 1			Balik A	atulo	and)							

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and	Mental Hy	giene	
		1 - State Registrar Certificate of Death		Reg. No. 0	25310
		1. Decedent's Name (First, Middle, Last)	2. Date of De. Month		3. Time of Death
Physicia /Medic		GARY BLOSE	AVG	8 2004	3 45 PM
Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	th	4c. County of Death	
		GILLChrest Hospice Towson		BALTIN	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	. (Month, Da	y, Year) Count	ace (State or Foreign
Director		215 - 40 - 1677	March .	27,1942	MD.
/land		10a. State 10b. County 10c. City, Town or Location		10	d. Inside City Limits
Many	to	MO BALTIMORE White MARSH			1 Yes 2 No
ith the Marylar or 28a-f ahow	Director	10e. Street and Number LOT IA 10f. Zip Code		10g. Citizen of What Count	ry?
ith with the Maryla 23a or 28a-f ahoi ust be nottlied at	ai	11540 Philadelphia RD. 21162		U.S.A	•
er dea items	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No	- 14. Race - America Black, White, e	
36 s afte	y FL	1 Never Married 2 Married 1 Yes 2 No Specify:		Specify:	T
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hyther than "neturel; or items 23e or 28e-f ahow ent, the Macilcal Engrelier : sast be mailibed at	Completed by Funeral	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/Indi	116
115. in 72	ojet	(Specify only highest grade completed) (Give kind of work done during most of wo	orking	160. Kind of Business/fild	ostry
21215 d within 7. piene. r than "n	E o	Elementary/Secondary (0-12) College (1-4or 5+) Chef		RESTARNIT	FIRM
nd 2 e filed ti Hygi other vent,	Be C		me (First, Middle,	Maiden Sumame)	
Irylanc should be f and Mental I marked of	To B	Kichard BLose ELIZA	Beth S	WAIR	
Maryland d 2 should be file in and Mental Hy it is marked oth treumatic event		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri	ural Route Numbe	er, City or Town, State, Zip (Code)
C = 14 F		Heide MARGOLIS 3358 FLOYD TR. L	05 Anse		68
- \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Tov	vn, State
Imor Pages ment of lent: If it	1	"4 Donation 5 Other (Specify) BAYVIEW Crematory 9	1104	Balto. M.	١.
Baltimore, permit Pages 1 a Inportent: If item any injury or other one.		21. Ignatur of Funeral Service Licensee 22. Name and Address of Facility HARTLey Miller		uneral Home o	CHTD.
8		1 Julie 7 Julies 7527 har GOLD RI		No 21234	
		23a. Paint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ic or respiratory a		Approximate Interval Between Onset and Death
Physician		mmédiate Cause (Final disease or condition resulting in death) a. Congestive Heart Faulur resulting in death)	-l		yean
/Medical Examiner		Due to (or as a consequence of):		,	O
	ē	Sequentially list conditions, if any, leading to immediate b. Scheme Candro my disconnections of the control o	Opart	7	years
ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			0
8760, cate be executed physician and into burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			_
8760 cate be e	dical	d			
(b) ((b) ((c) (ISSEMILE.			
2004 (C. Box 6. death certifications)	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deliver	,
• 0 00	slci	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		Month (Day Year
, AUGUST 84k 2001 Records, P.O. Bo The law requires that the death the has been signed by the atter tage 2 should be deteched for the	ompleted by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did t	obacco use contribute to the	agues of death?
	by	chanic obstructive lung disense	1 🗆 1	>	bly 4 Dunknown
ecords, law requires that as been signed 2 should be expensed.	etec	chomic rend facture	-		
Rec Rec	Idm	Chomic and Jacobs	24a. Was autop	an 24b. Were autop prior to com irmed? death?	sy findings available ipletion of cause of
	O		1 ☐ Yes	2No 1 Yes	2 🗆 No
of Vital of Vital Physicien: This certificat ral director, p	Be c	examiner?	ath (Check only o		17
Sun of of Phys	T. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Nother (Specify) how injury occurred	Hospice
⊆ 2 2 2 5 6	atlor	1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
CARY Division Tor Attending after death. Director: After in by the func	ertification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (: City or Tox	Street and Number or Rural	Route Number,
Div	Cert	Sunding, Sto. (Specify)	Sily 5. 7 5.	wit, oldio)	
SUSE, GARY Divisio The Hospitel or Attendi in 24 hours after death. The Funeral Director: A pletely filled in by the t	edical	29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place Check only	e, and due to the turred at the time,	cause(s) and manner as sta date and place, and due to	ited. the cause(s)
BLOSE, G. Div To the Hospitel or A within 24 hours after To the Funeral Dire completely filled in b.	Med	one) and manner stated. 29b. Signature and title of certifier 29c. License number	1	29d. Date signed (Month, D	
T with	_		-		
Ti.		30. Name and address of person who completed cause of eath (Item 23a) (Type, Print) W. A. Riley GBMC 6701 No Charles.		rregusi 7	1000
1		J. Name and address of person who completed cause of feath (term 25a) (Type, Print)	(B	alte md	20201
		Will I - Cold I I Col	<u> </u>		

Registrar

31. Date filed (Month, Day, Year)

AUG 1 2 2004

Patient known as Byrd Jeanne

			i icase	State of Marylar					gieno	•
			1 - For State Registrar	Otate of Marytar		rtificate of		Wentarry	2006	25311
			Decedent's Name (First, Middle, Last	st)		inouto or	Dodin	2. Date of De	Reg. No. U Y	3. Time of Death
П	Physici		Jeanne Patric	e Dubel Byrd				Augus	+ Day 200	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea		4c. County of De	
			Sinai Hospital	of Baltimon	æ	Bultin	none cis	4	n/a	
	Funeral		5. Social Security Number 6. S	THE OWNER		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bi	av. Year)	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	LM 2LAF 49	Yrs.			Sept.	28, 1954 B	altímore, MD
	land w		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 sh	tor	Maryland Baltin	nore	Baltim	ore				1 ☐ Yes 2 🛣 No
	n 288	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	hours after death with the Maryland tursi, or Itams 23a or 28a-1 show al Enails at ritial be hulfilled at	alD	6700 Bonnie Ridg	ge Drive Apt.	102	2120)9		United St	tates
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	Hispanic Origin? (San, Mexican, Puer	Specify Yes or No to Rican, etc.)		nerican Indian,
30	or the	by Fι	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give		1 ☐ Yes 2 🛣 No			Specify: W	
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural; or Itams 23s or 28s-f show event, Ita Medical Exar, fact must be putified at	ed b	15. Decedent's Ed	Year or Dates:	16a Door	dent's Usual Occur	nation			
Ċ	within 72 ene. then "nat	Completed	(Specify only highest gra	ide completed)	(Give	kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Busines	ss/industry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 4 years		Homema			own ł	iome
	e filed within al Hygiene. I other than 'vent, I'm Ne	Bec	17. Father's Name (First, Middle, Last)				Y	me (First, Middle	, Maiden Sumame)	
Maryland	should be nd Mental marked c	ToE	Dr. Robert Y. I	Oubel			He	len M. N	Miles	
a	01 00 00 00		19a. Informant's Name/Relationship (Parenes	T.				er, City or Town, State	, Zip Code)
	1 and Health 16m 27 other tr	W	Mr. & Mrs. Robert			Prince G		The second secon	imore, MD	21207
0	Pages 1 nent of H int: if Ite iry or otl		20a. Method of Disposition 1 ☐ Burial 2 【3 Cremation 3 ☐			sition (Name of natory or other pla		Date	20c. Location - City	
Baltimore,	permit. Pages Deportment of I Important: if to any injury or o		'4 □Dopertion 5 □ Other (Specifi	y) Soi	ith Car	roll Cre	matory A	ug. 11,	2004 Winfi	eld, Marylan
e D	Dep Imp		21. Signature of Funeral Service Licer	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	, 22	2. Name and Addre Surrier-Q	ueen Fun	eral Hom	ne & Cremat Wintield,	ory. PA
-			23 Part Enter the disease, or com	plications that caused the leaf	h Donot ent	.Z1Z W. U	Id Liber	ty Road	Wintield,	
			show, or heart failure. List only	one cause on each line.			4	o or rospiratory a		Approximate Interval Between Onset and Death
7	Physician /Medical	(disease or condition resulting in death)	a. End Star Due to (or as a consec	40/	iver o	lisease			
ı	Examiner			Ra . 1 6	4:1.	1 0				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	juence of):	<i>r</i> .c				
	cuted nd ransit	Examiner	triat initiated events	C						
/60,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consec	juence of):					
8/6	death certificate be executed e attending physician and nd for use as the burial-transit	dicai	•	d						
29 X	eath certific attending p	/Med	IF FEMALE:	23c. If yes, outcome of pregna	anov.					1
ROX	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Feta	ıldeath 3□	Ectopic pregnancy	4		23d. Date of d Month	elivery Day Year
o.		ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknown	leaur 3L	Other (specify) _				
1	The law requires that the te has been signed by the bage 2 should be detache		Part II. Dther significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use contribute	to the cause of death?
ecords,	quires n sign ald be	ed by						1 🗆	Yes 2□No 3🔀	Probably 4 Unknown
 ပ္ပ	s been si s should	Completed						24a. Was	an 24b, Were	autopsy findings available
X.	The lav	om							prior to primed? prior to death?	completion of cause of
Vita		Φ	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o	2 No 1 Ye	s 2X No
01 <	97 U =	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatien	t 3 DOA Oth	ier: 4 🗌 Nursing I	lome 5 ☐ Resi	dence 6 □Other (Sp	ecify)
	ding Phy h. After this funeral c		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe	how injury occurred	
20	Attendi death. ctor: A y the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	1			Yes 2 No			
Division	fter d frect direct	Certification:	4 Homicide determined		ome, farm, str y)	eet, factory, office		28f. Location (City or To	Street and Number or I wn, State)	Rural Route Number,
	pital ours a eral [29a. Certifier 1 Certifying Ph	usoloine. To the best of each						
	24 hc 24 hc Fun etely	edical	(Check only one) Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	ition and/or in	vestigation, in my o	ne, date and place pinion, death occi	rred at the time,	date and place, and di	as stated. ue to the cause(s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier	7		29c. Licens			29d. Date signed (Moi	nth, Day, Year)
	/		1 HBasta	MD		RES	-000		August,	9,2004
	5	1	30. Name and address of person who	,	n 23a) (Type,	Print)	1. 1. 1.	6 D 11		
			Hany Basha	7 11	Sina	MOSPI	Tal of	beut	·more	
J.	Sta Registr	-	31. Date filed (Month, Day, Year) AUG 1 2	2004 32. Registrar's Signa	ature	Space	de la		August,	

		-	For State Registrar	State of M	aryland / I	Departme Certifica			ind Me	, ,	iene	2531	2
	Physicia /Medic		Decedent's Name (First, Middle, Last, BERNICE		SON	BELLU	CCI			2. Date of Death Month Augus t	Day	3. Time of Year 0 0 4 5 : 4]	
	Examin		4a. Facility Name (If not institution, give Frederick Memo				ity, Town, or reder		of Death		4c. County of		
	Funeral Director		041-18-7705	x 7. Ag]M 2⊠F	e (In yrs. last bi	Yrs. If Un Monti	der 1 Year ns Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, pril 16	Year) 1922	9. Birthplace (State o Country) Connecticu	
	show	J.	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow		1					10d. Inside Ci	
	h the M or 28a-f	Director	Maryland Frederic	CK .		Frederi 10f.	C K Zip Code			10	Og. Citizen of W		28.110
	ath wi	ral	3132 Basford Road					1703				States	
36	hin 72 hours after death with the Maryland B. an "natural", or terms 23a or 28a-f show Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			cedent of Hispecify Cuba s 2 🔯 No	ispanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		- American Indian, r, White, etc. White	
21215-0036	"nai	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			I. Decedent's U (Give kind of life. DO NO	work done of	during most	t of working	7	16b. Kind of Bus	siness/Industry	
121	filed within Hygiene. Other than		17. Father's Name (First, Middle, Last)	2		Homema	ker	10 Math	de Nome /	Time Adiabata A	Own Ho		
Maryland	ed stal	To Be	Fridolf V. Carlso					Ann	ie St	ankard	faiden Sumame	,	
Mai	d2 sthartharthartreu	ł	19a. Informant's Name/Relationship (T) Edward M. Bellucci								City or Town, S		
ore,	ss 1 and of Health Item 27 other tr		20a. Method of Disposition		20b. Place o	of Disposition (Da	te 2		City or Town, State	
Baltimore,	Page ment cent: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☑ Other (Specify)		Gate o	of Heav ery Mau	en soleu	n 2	Augus 200	4 S		pring, Mary	
Bali	permit. Pages 'Department of H Importent: If Ite eny injury or ot once.		21. Signature of Funeral Service Licensee M00198 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, 300 West Montgomery Ave., Rockvill									ckville, I MD 20850-280	Inc. 5
	Pnysician	į g	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	lications that cause ne cause on each li a	ine.	not enter the r	node of dyin	g, such as	cardiac or i	respiratory arre	est.	Approximate Interval Betwood Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Cons	ween Death
	/Medical Examiner		resulting in death)	_	a consequence	of):						3017	S
	led sit	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clease or known	V	a consequence	of):						3,	
8760,	ate be executed hysician and the burial-transit	ical Examine		Due to (or as	a consequence	of):							
9	ntificate I ng physi s as the b	Medic	IF FEMALE:	0									
.O. Box	The law requires that the death certific ten has been signed by the attending page 2 should be detached for use as in	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal deat	h 3 ⊟Ectopi 5 □ Other	c pregnancy (specify)				23d. Date Mon	of delivery th Day Y	ear ear
Records, P.	quires that n signed by uld be deta	by	Part II. Other significant conditions co	ntributing to death t	out not resulting	in the underlyin	ng cause give	en in Part I.			_	bute to the cause of do	
ооа	e law requ has been ge 2 shoul	Completed	CONGESTIVE	+ SART	FAILL	RE				24a. Was an	24b. W	ere autopsy findings a	available
			NON ST ELE	EVATION	MYDO	ARDIAL	INF	ARCT	TON	perform 1 Yes 2		rior to completion of ca eath? Yes 2 No	
Vital	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2□ER/O	utnationt 3	DOA Oth			Check only one		/Specific	
ion of	ding h. After fune	1 Yes 2 No											
Division	el or Attender safter deatl	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	jury - At home, f tc. <i>(Specify)</i>	farm, street, fac	tory, office		28	If. Location (Str City or Town		r or Rural Route Numi	ber,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical (29a. Certifier (Check only one) Check only 2 ☐ Medical Exam	sician: To the best iner: On the basis of and manner st	of examination a	ge, death occur nd/or investiga	red at the tin tion, in my o	ne, date an pinion, dea	d place, an th occurred	d due to the ca d at the time, da	use(s) and man ate and place, a	ner as stated. nd due to the cause(s))
)	Tot Tot com	Σ	29b. Signature and title of certifier	ma Mil	0		29c. Licenso	9 number 577	96			(Month, Day, Year) 9, 2004	
	20		30. Name and address of person who c										
	Sta	ate	Lalit Verma, M.D. 31. Date filed (Month, Day Year)	, 400 Wes	st Sever				ick,	Maryla	nd 2170	<u>l</u>	
	Regist		31. Date filed (Month, Day, Year)	4 Agras	/	& By	racks						

			1- State of Maryla		artment of Heartificate of De	eath	Reg	ene	25313		
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) Denita Brown			2	2. Date of Death Month Hugust	Day Day Year	3. Time of Death 925 A M		
)	Examir		4a. Facility Name (If not institution, give street and number) Son Cools Hospi 5. Social Security Number 6. Sex 7. Age (In yr.	fal rs. last birthday)		Honor		4c. County of Death			
Ŀ	Funeral Director		219-62-5289 1 M 2 DF 4	7 Yrs.		Hours Min.	3. Date of Birth (Month, Day, Ye 11-30-1	(ear) 9. Birth 1956 MAR	place (State or Foreign intry) YLAND		
	the Marylan 28a-f show	rector		City, Town or Lo			100	. Citizen of What Co	10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
36	72 hours after death with the Maryland natural, or itams 23a or 28a-f show Jeal Examinational be mailfied at	by Funeral Director	2521 RAUNAH AVE. 11. Marital Status 1 Never Married 2 Married 1 Yes, Give	ı	21216 Was Decedent of Hispa If Yes, specify Cuban, I 1□ Yes 2⊠No S	anic Origin? (Speci Mexican, Puerto Ri Specify:		USA 14. Race - Amer Black, White Specify: BI	ican Indian, , etc.		
21215-0036	I within iene.	Completed b	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- -4-	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	n ng most of working	7	16b. Kind of Business/Industry RITE AID			
Maryland	should be filed and Mental Hygie markad othar umatic evant, II	To Be C	17. Father's Name (First, Middle, Last) JAMES BROWN			. Mother's Name (
	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) SHIRLEY BROWN (MOTHER)	252	ng Address (Street and 21 RAUNAH A	AVE. BALT	IMORE, M	ARYLAND 2	1216		
Baltimore,	permit. Pages 1 a Department of Hez important: If itam any injury or otha		1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	ETRO CRI HIBNER	natory or other place)		004 BA		MARYLAND		
	Physician /Medical Examiner	Examiner	23a. Part Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cisease or mijury that initiated events	equence of):	er the mode of dying, s newmon AID_S		respiratory arrest,		Approximate Interval Batween Onset and Death		
. Box 68760,	death certificate be executed e attending physician and ad for use as the burial-transit	Physician/Medical Exa	Due to (or as a consect of the following of the past 12 months? 1	gnancy etal death 3	Ectopic pregnancy			23d. Date of delive	ery Day Year		
rds, P.O	that the ed by th detache	by	9 2 Unknown 9Ll Unknown Part II. Other significant conditions contributing to death but not re	esulting in the ur	nderlying cause given ir	n Part I.		co use contribute to	he cause of death?		
Vital Records,	iician: The law requires certificate has been sign rector, page 2 should be	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of 2 No		
Division of Vit	ing Phys After this uneral di	ertification; To Be	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suignite 6 Could not be		t 3 DOA Other. 28c. Injury at Work? M 1 Yes	286 2 🗆 No	5 ☐ Residence				
DIVI	7 9 5 7	dical Certifi	4 Homicide determined 286. Place of injury - At building, etc. (Spec	nined 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number of Rural Route No. 1975) 286. Location (Street and Number of Rur							
r	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medic	29b. Signature and title of certifier	July July	29c. License nu	on, death occurred	at the time, date	and place, and due t Date signed (Month,	o the cause(s)		
2			30. Name and address of person who completed cause of death (little 2000 U. Balfred (1804) 1904	54							
	Sta Registr	*	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature &	Sports	•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 July 27, **Physician** 6:00 PM M Mildred G. Coleman /Medical 4c. County of Death
Ba 140 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 707 Belle Terre Avenue Baltimore 8. Date of Birth Month, Day, 1 If Under 1 Year | If Under 24 Hrs. 6 Sex 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Year) 1 ☐ M 2 K F 415326682 enn Director Usuel Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Exacine rount be notified at MD 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 707 Belle Terre Avenue 21218 Completed by Funeral 12. Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 Married Specify: White ō 1 ☐ Yes 🕍 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me. Elementary/Secondary (0-12) College (1-4or 5+) grede waitress restaraunt 17. Father's Name (First, Middle, Last) er's Name (First, Middle, Maiden Sumame) Be 8 unknown Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Carolyn Buckley/daughter 707 Belle Terre Avenue Baltimore. MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or otl 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signaturo A Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an certificate has the irector, page 2 s autopsy 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No ٥ 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After 1 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

5629 Loub C.
31. Date filed (Month, Day, Year)

Robert Carlyle

04-0435	8	• •		delible ink. Ensure A artment of Health and N	-	•
MAN		1 - State Registrar	· ·	rtificate of Death	Reg.	
Physic /Med		1. Decedent's Name (First, Middle, Last) Robert Carlyle			2. Date of Death July 03,	Day Year 2004 1805 P M
Exami		4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of Death		4c. County of Death
		842 Park Avenue Apa 5. Social Security Number unk 6. Sex	7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9 Rithplace (State or Femiles
Funeral Director		1 M Usual Residence of Decedent		Months Days Hours Min.	July 21,	1923 9. Birthplace (State or Foreign unk
ryland how		10a. State 10b. County MD	10c. City, Town or Lo			10d. Inside City Limits
Ba-f s	cto	TID	Balti	lmore		1 ∑ Yes 2 ☐ No
with the a or 2	Funeral Director	10e. Street and Number 842 Park Avenue #20	4	10f. Zip Code 21202	10g.	Citizen of What Country? USA
death ns 23	era	11 Marital Status unk 12. V		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
215-0036 thin 72 hours after death with the Maryland ie. ian "natural", or items 23a or 28a-f show Medical Exerciter Frust the rectified at	þ	1 Never Married 2 Married 1	rmed Forces? □Yes 2□No unk	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, etc. Specify: black
5-0 72 hc	eted	15. Decedent's Educatio (Specify only highest grade cor	n 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing unk 16t	b. Kind of Business/Industry unl
2121 ad within rgiene.	Completed	Elementary/Secondary (0-12) unk unk	college (1-4or 5+)	DO NOT use retired)		
ind 2 be filed tal Hygi d other	To Be Co	17. Father's Name (First, Middle, Last)		unk 18. Mother's Nam	e (First, Middle, Mai	den Sumame) unl
aryla	-	19a. Informant's Name/Relationship (Type, F	Print) 19b. Mailin	ng Address (Street and Number or Rur	al Route Number, C	ity or Town, State, Zip Code)
and 2	1	O.C.M.E.		l Penn Street Balt		21201
Baltimore, permit. Pages 1 a Department of Hes mportent: If Item any injury or othe once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remo 1 □ Donation 5 □ Other (Specify) 1:	valirom State	osition (Name of matory or other place)	Date 200	: Location - City or Town, State
Balti permit. Departr importe any inje		21. Signature of Funeral Service Licensee Ronald S Wat	. / / 22	2. Name and Address of Facility tate Anatony Board allimore, MD 2120	655 W. B	altimore Street
Physician // Medical Examiner properties and principal-transit properties of principal franci	cai Examiner	sock, or heart failure. List only one call mm. late Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence of): Due to (or as a consequence of):	Pensaleutic Cox	lovorcula	Interval Between Onset and Death
I Records, P.O. Box 687 The law requires that the death certificate the has been signed by the attending phys page 2 should be detached for use as the	Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P luires than n signed I	þ	Part II. Other significant conditions contribu	iting to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death? 2 \(\text{No} \) \(3 \text{Probably} \) \(4 \text{Unknown} \)
Vital Records, sticlen: The law requires to certificate has been signs lirector, page 2 should be	Completed		-		24a. Was an autopsy performed	
of Vital Physicien: T	Be	25. Was case referred to medical examiner? 1.77 Vac. 3 7 No. Hospi	tal:	O#	h (Check only one)	
P F F B	tion; To	12 165 2 110	1 ☐ Inpatient 2 ☐ ER/Outpatier Ba. Date of Injury (Month, Day Year) 28b. Time o Injury	1 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how i	e 6XXNther (Specify) At SCENE njury occurred
Division of or Attending stiter death. I Director: After d in by the fune	Certification;	3 □ Suicido 6 □ Could not be	Be. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, St	t and Number or Rural Route Number, tate)
To the Hospitel within 24 hours a To the Eunerell completely filled	Medicai	(Check only 2 Medical Examiner:	n: To the best of my knowledge, deat On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To th withir To th comp	Me	29b. Signature and titler of certifier	^	29c. License number	29d.	Date signed (Month, Day, Year)
		1 Korker	U)	O.C.M.E.	J	uly 04, 2004
		30. Name and address of person who comple	eted cause of death (Item 23a) (Type,	Print) 11 Penn Street, Ba	altimore,	Maryland 21201
St Regis	ate trar	AUG 1 2 2004	32. Registrar's Signature	rels		

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be executed inding physician and use as the burial-transit signed by the at d be detached for within 24 hours after death.

To tha Funeral Director: After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

10a, State

Director

φ

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant, the Medical Examinar must be notified at once.

Physician

/Medical

Examiner

Physician/Medical Completed by Be Certification: To

Medical

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

> 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

CONRT

29a. Certifier

3 Suicide

4 \(\text{Homicide} \)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature ded title of certifier

6 Could not be determined

29c License number (1) 42723

OLD

5401

2004 AUGUST 06

s of person who completed cause of death (Item 23a) (Type, Print) AUVERAHALLI HARISH 3

R'ANDALIS TOWN

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Month Physician \mathbf{P}^{M} Hilda Devi August 9, 2:00 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 406 Clagett Drive Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 6, 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 57 1947 577-25-6012 Director Burma Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or items 23a or 28a-f show 1X Yes 2 □ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 406 Clagett Drive 20851 Burma Completed by Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☑ No 1 Never Married 2 対 Married traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: If Yes, Give Year or Dates: Yes. Give Specify: Burmese 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 11 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other traumatic even 2008. Be Jang Prasad Lexmi Devi 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 Clagett Drive, Rockville, Maryland 20851 Dilip Kumar/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Date 20a. Method of Disposition 20c. Location - City or Town, State August 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, 21. Signature of Funeral Service Licensee M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Cerebrovascular Accident /Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. physician Physiclan/Medical the as attending use IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f o 9 Unknown ۵ signed be del Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Diabetes Mellitus Type II 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should L Cerebrovascular Accident 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an 1 ☐ Yes 2 X No Division of Vital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛣 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1.XYes 2 No Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 XNatural 5 Pending after death. t Director: Af М 1 ☐ Yes 2 ☐ No investigation 2 Accident the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide o the Hospital within 24 hours a To the Funeret I completely filled 29a. Certifier 1XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35370 August 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jan Bachowski, M.D. 11125 Rockville Pike #104, Rockville, Maryland 20852

State Registrar d (Month, Day

31. Date filed (Month.

CON KA

3. Registrar's Signature

		1 - For State Registrar	State	of Maryla		artment of H rtificate of				iene g. No. 11	nI.	25310
Physic		Decedent's Name (First, Middle,	,	ny Dugi	••				2. Date of Deat Month August	h Day	Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution,			ie	4b. City, Town, o	r Location o	of Death	August	_)04 ity of Deatl	1:00 PM M
LAGITII	ic.	Fox Chase					Silver		ina			gomery
Funeral			6. Sex	7. Age (In)	rs. last birthday)	If Under 1 Year	If Under a		8. Date of Birth (Month, Day,	1		hplace (State or Foreign untry)
Director		073-34-0847	1□M 2🕅 F	76	Yrs.	Months Days	Hours	Min.	November 1	2, 1927	Co	untry) Colombia
P.		Usual Residence of Decedent										
urylar show	_	10a. State 10b. County		10c.	City, Town or Lo	ocation						10d. Inside City Limits
Ba-f.	cto	Maryland Mon	ntgomery]	Bethes	sda				1 ☐ Yes 2X No
or 2	Funeral Director	10e. Street and Number				10f. Zip Code			16	og. Citizen o	f What Co	untry?
ath w	ra .	4710 Bet					20814			Uni	ited	States
er de	nue	11. Marital Status	Armed	ecedent Ever i Forces?	n U.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Ori <u>c</u> an, Mexican	gin? (Spec i, Puerto R	cify Yes or No- lican, etc.)		ace - Ameriack, White	rican Indian, e. etc.
rs aft	by F	1 X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	s 2 X No Give		1X Yes 2□ No	Specify:	0.1		Spec	eify:	
Pour Pour	ed t	15. Decedent		Dales.	16a Doca	dent's Usual Occup	ation	COT	ombian	ich Kind -t		White
in 72 in 72	Completed	(Specify only highest	grade complete		(Give	kind of work done DO NOT use retired	durina most	of working	g	16b. Kind of	Business/i	industry
iene.	E	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		Nii	rse			1	Jool +1	h Care
Hyg other	BeC	17. Father's Name (First, Middle, L	ast)			110		r's Name ((First, Middle, N			n care
id be ked ked	To B]	Propero	Duque					Carl	ina Pa		
shound M	-	19a. Informant's Name/Relationsh			19b. Maili	ng Address <i>(Street</i> Gatehead	and Numbe	r or Aural				ip Code)
nd 2 alth a 27 is		Monica Solano/ N	liece		3424 Silv	er Sprin	d Manc	or Wa Tvlan	y #202 d 20904			
itam oths		20a. Method of Disposition		20	b. Place of Dispo	sition (Name of		Da	ite 2	20c. Location	- City or 1	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinatmet be notified at ances.		1 X Burial 2 □ Cremation `4 □ Donation 5 □ Other (Sp		m State	Gate of Heave	natory or other place n Cemeter	•v	Augus		ilwar (Carin	g, Maryland
mait.		21. Signature of Funeral Service L	icensee	/	22	2. Name and Addre	ss of Facility	v Robe	rt A. P	umphre	ev Fu	neral Home/
Department of the sany in		Van.	1/2/	. 1 M	Β€	thesda-C	hevv (Jhase	. Inc.	1331 V	VISCO:	nsin Avenue
Physician /Medical		23a. Part1. Enter the sease, in c shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	aCaro		iratory		ng, such as o	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
icate be executed minimal physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate that Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lung Due t	Cance o (or as a cons	sequence of):							2 Months
rtificate ba eving physician as the buria		IF FEMALE:	d.									
To the Hospital or Attanding Physician: The law requires that the death certification is the record of the Hospital or Attanding Physician: The law requires that the death. To the Funaral Director: After this certificate has been signed by the attending complately filled in by the funaral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 Live	outcome of pre e birth 2 F gnant at time o known	etal death 3	Ectopic pregnancy Other (specify)					ate of delivi	very Day Year
w requires that been signed b should be deta	by Pł	Part II. Other significant condition	s contributing to	death but not	resulting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use cor	ntribute to	the cause of death?
w requires to be signed should be.		Generalized De	bility						1 🗆 Ye	s 2 💢 No	3 ☐ Pro	bably 4 Unknown
w rec	Completed								24a. Was an	24h	Were aut	opsy findings available
he lav	E								autopsy	' I	prior to co death?	ompletion of cause of
VICAL Iclan: T certificat ector, pi	Ö	25. Was case referred to medical					00 Pt	. (5) . 11 . 1	1 X Yes 2		1 🗆 Yes	2 No
raicia s cert	0 B	examiner? 1 ☐ Yes 2 ី🗙 No	Hospital:	☐Inpatient 2	2 ER/Outpatien	t 3□ DOA Oth			Check only one 5 □ Resider		h (0	
ding Physician: The land Affection of the continuation of the cont	n: T	27. Manner of Death	28a. Dat	te of Injury	28b. Time of	28c. Injun	y at	28	d. Describe how	v injury occu	rred	ny)
Attanding F ar death. ector: After by the funar	atio	1 XNatural 5 Pending 2 Accident investiga		onth, Day Year	r) Injury		k? Yes 2∐N	No				
Atta Atta by the by th	ifici	3 Suicide 6 Could no 4 Homicide determine	280. Pla	ce of Injury - A	t home, farm, str	eet, factory, office		28	f. Location (Str	et and Num	ber or Rur	ral Route Number,
s afte	Certification:	4 Hornicide	Dui	Iding, etc. (Sp.	ecity)				City or Town,	State)		
To the Hospital or Attandi within 24 hours after death. To tha Funaral Director: A complately filled in by the fu	Medicai (29a. Certifier 1 Certifying (Check only one)	xaminer: On the	he best of my basis of exam anner stated.	knowledge, death nination and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, deatl	place, an	d due to the car I at the time, da	use(s) and m te and place	nanner as s , and due i	stated. to the cause(s)
To ti Withii To ti	Ž	29b. Signature and title of certifier	01.			29c. Licens	e number		29	d. Date sign	ed (Month,	Day, Year)
		Justa	- PH	151 CI	AN	200	6109	9 6		Λ.,,	7110 +	9, 2004
4		30. Name and address of person w	no completed ca	use of death (Item 23a) (Type,	Print)				Aus	sust	9, 4004
0		Usha V. Gollapa	lli, M.D	. 8609	Second	Avenue #4	04B S	ilvei	r Spring	g, Mar	yland	1 20910
St	ate	31. Date filed (Month, Day, Year)	2004 32.	Registrar's Si	gnature	1	A .					-0720

DHMH 17 Rev 1/2001

AUGUST 2, 2004 7:01 p.m.

		For	Please	Type or Prir State of Ma		/ Depa	artment of H	lealth and	-		-		
		1 - State Registrar				Cei	rtificate of	Death		Reg. No.	004	253	19
Physici /Medio			e Gilbert	Dean					2. Date of De Month Augus	Day	Year 2004	3. Time o	of Death
Examin	er		. 3	ve street and number)				r Location of Deat	h		County of Dea		
Funeral		5. Social Security N	laris Hos		e (In yrs. las	t birthday)	Timor If Under 1 Year		8. Date of Bi	rth	Baltimo 9. Bir	thplace (State	or Foreian
Director		212-18-9	63/	1□ M 2□ F	84	Yrs.	Months Days	Hours Min.	July 1	ay, Year)	C	nois	
ryland how		10a. State	10b. County		10c. City, 7	Town or Lo	ocation					10d. Inside C	•
8a-fs	Director	MD	Baltimo	re	Co	ckeys						L	2 No
with the or 2	Dire	10e. Street and Nu		Diago #T#			10f. Zip Code			10g. Citi	zen of What Co	,	
heath ms 23	Funeral	10/06 WE	stcastie	Place #T4	Ever in U.S.	13.	21030 Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S	pecify Yes or N	D-	14. Race - Ame	SA erican Indian,	
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or frems 23a or 28a-f show other traumatic event, the Marylaal Examinating to natified at	by		ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			If Yes, specify Cuba 1 ☐ Yes 2 🙀 No	an, Mexican, Puèr Specify:	ò Rican, etc.)		Black, White	vhite	
nin 72 ho	Completed		15. Decedent's E	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Ki	nd of Business	/Industry	
ad with	Com	Elementary/Second 12	oridary (U-12)	College (1-4or 5		Home	maker			C	wn Ho	me	
d be file	Be (17. Father's Name						18. Mother's Nai		, Maiden	Sumame)		
y Indian Men marke natic	70		E. Gilber			105 14-16			Ilhimer	- 0"		T. O. (1)	
od 2 st d 2 st th and traun traun			ame/Relationship	n/husband			ng Address (Street Westcas					-,	130
s 1 and f Health ftem 27 other tr		20a. Method of Dis	position		20b. Plac		esition (Name of matory or other place		Date		cation - City or		30
Pages nent of I int: If it		1 ☐XBurial 2 `4 ☐ Donation	☐ Cremation 3 5 ☐ Other (Spec	Removal from State	İ		Valley M	, ,		Tim	onium,	MD	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.			neral selvice Lice	Carit		22	Lemmon F 0 W. Pac	ss of Facility		Dula	aney Va	alley,	Inc.
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/Medical Examiner		resulting in de in		Due to (or as			d of the	THIOME					
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nted Insit	Examiner	Sequentially list or if any, leading to it cause. Enter Und	erlying	20010 (01 43	a conseque	1100 017.							
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ite be nysicia ne bur	cal		•	d.									
certificate of the seas the seas the	Med	IF FEMALE:								- 1			
atter for u	Iclan/Medic	23b. Was deceded in the past 12	2 months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	у		2	23d. Date of de Month		Year
the day the	hysic	1 ☐ Yes 2 9 ☐ Unknow		9□ Unknown	t tillse of deal	5	_ Ottler (specify) _						
w requires that the deben signed by the should be detached	by P	Part II. Other sign	ificant conditions	contributing to death b	out not resulti	ing in the u	nderlying cause giv	ven in Part I.			se contribute to		
law requires as been sign 2 should be	ompleted								24a. Wa:	s an	24b. Were at	atopsy findings	available
The The ate h	e Com	25. Was case refe	grad to madigal						1 ☐ Yes	ormed? 2 X No	death?	completion of a	cause of
99	0 8	examiner?		Hospital:	ent 2 EF	R/Outpatier	nt 3 DOA Oth	26. Place of Dener:	atn <i>(Check only</i> Iome 5 ☐ Res		6 ▼ Other (Spe	cify) HACE)TCE
– 6 9 9	on: T	27. Manner of Dea		28a. Date of Inju (Month, Da	ay Year)	8b. Time o	f 28c. Injui		28d. Describe			HOST	TOE
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DIVISION OF Spital or Attending Phous after death. Betal Director: After the filled in by the funeral	Certification:	4 Homicide	determine	d 200. Place of in	tc. (Specify)	ie, rarm, sti	reet, lactory, office			(Street an wn, State,	d Number or Ri)	urai Houte Nun	nber,
H P P P P P P P P P P P P P P P P P P P	Medical C	29a. Certifier (Check only one)	1 X Certifying F	Physician: To the best arriver: On the basis of and manner st	of examinatio	edge, deat on and/or in	h occurred at the till evestigation, in my o	me, date and place opinion, death occi	a, and due to the urred at the time	cause(s) , date and	and manner as place, and due	s stated. to the cause(s)
To the Hos within 24 h To the Fur completely	Me	29b. Signature and	d tite of certifier				29c. Licens			29d. Dat	e signed (Mont	h, Day, Year)	
)		10			リリ	13725		Αι	igust 3	, 2004	
				o completed cause of									
<i>y</i>	ate		RIQ MAHMO nth. Day, Year)	√ 32. Registr	rar's Signatue	re .	1	TIMONIUM	, MD 21	093			
Regist		31. Date filed (Mo.	1 2 2004	Denger	1	1	could						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryla		artment of H rtificate of I			Beg. No.	11.	25220
	Physicia		1. Decedent's Name (First, Middle, Las	•				2. Date of Dea Month		Year	3. Time of Death
-	/Medic	al	Donald		lliott,			Aug 4,			9:45 P M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. Count		
_			1404 Madison Dr 5. Social Security Number 6. S		. last birthday)	Fort Wa	ashington If Under 24 Hrs.	8 Date of Birth			orge's
	Funeral Director		578 48 0351	₩ 2□F	65 ^{Yrs.}	Months Days	Hours Min.	(Month, Day	, _{Year)} 10, 193	9 Was	lace (State of Foreign try) hington DC
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation					0d. Inside City Limits
	Aarylis f sho	5		George's	Fort Wa	shington					1 □ Yes 2 🏋 No
	the the	Director	10e. Street and Number	ocorge B	TOTE WE	10f. Zip Code			10g. Citizen of	What Cour	ntry?
	3a or		1404 Madison	Drive		20	0744		Unit	ed St	O.t.o.o
	death ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Ra	ce - Americ	an Indian,
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Examinat must be motified at	by	1 Never Married 2 Married	1 ☐ Yes 2 (No If Yes, Give X X Year or Dates:		1 □ Yes 2 □X\X	Specify:	riican, olo.)	Speci	tv:	ite
0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	ation during most of work	ina	16b. Kind of E	Business/In	dustry
21	Jwithin 72 ho jiene. r than "natur	n pe	Elementary/Secondary (0-12)	College (1-4or 5+)	Self		during most of work	9	m .	0 5	
21		Co	7th		perr	Employe		1000 A B 41 adds	Towing		covery
nd	dal	Be	17. Father's Name (First, Middle, Last) Edward Tullis E				18. Mother's Nam		Maiden Suma	me)	
3	should be nd Mental s marked c	P			10h Maili	na Address (Street	Roberta and Number or Run		c City of Town	State Zir	Code
Mai	d 2 sho		19a. Informant's Name/Relationship (Deborah Ann Herni							r, Otato, 201	, 6000,
	1 an Heal am 2 ther		20a. Method of Disposition		Place of Dispo	JOHN Harr osition (Name of matory or other place	ison Road	l, Hardw	20c. Location	- City or To	nd 20776 own, State
Baltimore,			XX Burial 2 Cremation 3 C	JRemoval from State)				44.4.4.
Ė	그 된 건 글	1	21. Signature of Funeral Service Licer	msee	rt Linc	OIN CEMET 2. Name and Addre	ery Aug C	7, 2004L	Brenty	voed.	Maryland
Ba	permi Depa Impo any ir		1.4.5.5ix	WOOSHIT		Alexand	ria Ferry	runera Road	I Home,	,⊥nc (633 Old cyland 2073 5
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de	at o not en	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	1 9 - l'Ici I	Approximate Interval Between
	Priysician		Immediate Cause (Final	one cause on each line.	Con	~ 01	11.00				Onliet and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a cons	equence of):		my				1 111000
16	Examiner		Sequentially list conditions	b							
	pi ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence of):						
	and I-trans	хаш	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):						
68760,	rtificate be executed ng physician and as the burial-transit										
387	tificate ng phys as the	Medical	25	d							
) XO	attending for use a	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of prec		¬			23d. D	ate of deliv	ery
m	death cer e attendin d for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fe		⊒Ectopic pregnancy □ Other (specify) _	/		N	lonth	Day Year
P.0	t the by th	hys	9 🗆 Unknown	9□ Unknown							
	The law requires that the death ce ate has been signed by the attendi bage 2 should be detached for use	by	Part II. Other significant conditions	contributing to death but not r	esulting in the u	underlying cause giv	en in Part I.		obacco use coi Yes 2□No		he cause of death?
Records,	w require been si should I	Completed						24a. Was	an 24b	. Were auto	ppsy findings available
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a	in: Ti ificate or, pa	e C	25. Was case referred to medical				26. Place of Deal		2 X No	1 🗌 Yes	2 U No
Vital	Physician: r this certifica ral director, i	To B	examiner?	Hospital:	☐ ER/Outpatie	nt 3 DOA Ott		ome 5 XX Resi		ther (Specia	(y)
of	ding Physician: The I h. After this certificate he funeral director, page		27. Manner of Death	28a. Date of Injury (Month, Day Year,	28b. Time o	of 28c. Inju		28d. Describe			
ion	Attending r death. ector: Atteled to the fune	atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		Yes 2 □ No				
Division	r Atte er de recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		t home, farm, st	treet, factory, office		28f. Location (City or Tox		ber or Run	al Route Number,
	ital or irs afte ral Dir led in		XX								
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		hysiciah: To the best of my lander. On the basis of exam and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 mil)	29c. Licens		4	29d. Date sign	ed (Month,	Day, Year)
	/		> lall	ke(X)		DO	12975		8-	- 5 ,	09
•	15		30. Name and address of person who	completed cause of death (I	tem 23a) (Type						
_	10			, M.D. 11345			e, Suite #	#104, Wa	ldorf,	MD 20)603
	Sta Regist	ate rar	31. Date (AUG 1 2 , 2004	32. Registrar's Sig	marer e	foods					

	2. Date of Death	Year	3. Time of Deat
ertificate of Death	Rag. No.	004	2532
partment of Health and	Mental Hygiene	0 - 1	

Physician	
/Medical	
Examiner	

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f ehow any Injury or other treumatic event. It is Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Farlow, Richard

Physician /Medical Examiner

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

an	D.T.C.II.A.D.D. D.D.T.MIGGIE, L.							Month Day Year 7:15 P.					
al	RICHARD BRITTIN			•	41 01	_		V= 112	Augu		300		F , 1
er	4a. Facility Name (If not institution, gi			.	0.		-	of Death			County of De		- 1
	North Aru		spito		61	- 11		rnie		ľ	Inne	Aruno	101
	1	Sex. 7. Ag 1 ☐ M 2 ☐ F		ast birthday)	If Under Months		Hours	r 24 Hrs. Min.	8. Date of 8 (Month, I	Day, Year)	9. 5	irthplace (State of Country)	or Foreig
	213-44-1163		60	Yrs.					APR.	6,194	4 MI)	
	Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10d. Inside C	its Lienit
_					Oution							1 Tes	
ctc	MD ANNE AR	UNDEL	S	EVERN	-т								~ (2)511
- Fe	10e. Street and Number				10f. Zip					10g. Citiz	zen of What	Country?	
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Completed by Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. \	Was Dece	dent of H	ispanic C	rigin? (Spe	ecify Yes or I Rican, etc.)	No- 1	14. Race - Al Black, W	merican Indian,	
丘	1 Never Mamed 2 Married	1 ☐ Yes 2 🔀	No		1 ☐ Yes		Specif		, ,	ŀ	Specify:	WHITE	
ξ	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:				222110	0,000	,.			эреспу.	WILLIE	
je	15. Decedent's E (Specify only highest g	Education		16a. Deced	dent's Usua	al Occupa	ation	st of work	ina	16b. Kir	nd of Busine:	ss/Industry	
헏	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT u	se retired	1)		9				
Ö		4		AUDI	TOR					I	.R.S.		
Be (17. Father's Name (First, Middle, Las	st)					18. Moti	her's Name	e (First, Midd	fle, Maiden	Sumame)		
ToE	RICHARD BRITTING	HAM FARLOW	, SR.				MI	RIAM	HOLDCR	AFT			
_	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Num	ber or Rura	al Route Nun	nber, City or	Town, State	, Zip Code)	
	MR. DANIEL FARLO	W / SON		0002	HADE	ו תמר	шттт	CADT	II DAD	1777TT	T' MT	21227	
	20a. Method of Disposition	W / 30N	20b. Pl	lace of Dispo	sition (Nai	me of		GARI	H, PAR	20c. Lo	cation - City	or Town, State	
	1 ☐ Burial 2 X Cremation 3			emetery, cren				ATIC	12 200	CEE	TTENICTI	TTP MD	
	*4 Donation 5 Other (Spec		CHE	SAPEAK			1					LLE, MD	
	21. Signature of Haneral Service Le	ensee /										ME P.A.	
	(Su Co	Dec XII	1013	7							NIE, M	D 21061	
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that cause ly one cause on each l	d the death ine.	n. Do not ent	er the mod					arrest,		Approximat Interval Bet	ween
	Immediate Cause (Final disease or condition	Comm	Can a .	600	ton		dice	ase	•			Onset and	Death
	resulting in death)	Due to (or as	s a consequ	uence of):	10.0	ر م		ase.					
	0 11 11 11 11 11 11 11	Cong	1 French	in ha	art	Lan	lune	2 ٠					
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	uence of):		U							
Ē	Cause (Disease or injury that initiated events	- claret	oten	n	a sld	140							
Exa	resulting in death) Last	Due to (or as	s a consequ	uence of):									
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Iclan/Medical Examiner	IF FEMALE:	23c. If yes, outcome	e of pregna	ncv							23d. Date of	dolinea.	
lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic p		1				Month		Year
slc	1 Yes 2 No	9☐ Unknown	it tane or de	oaui J] Other (st	Jecny)				-			
Physi	Part II. Other significant conditions	contributing to death	but not recu	ulting in the u	ndorhina e	auce div	en in Dae	+ 1	23e Di	d tobacco u	se contribute	to the cause of c	doath?
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e C	25. Was case referred to medical					-	26 Pla	ce of Deat	1 Yes		101	65 2 140	
0	examiner? Hospital: Hospital: 2 FB/Outpatient						26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify)						
-	27. Manner of Death	28a. Date of Inj	ury	28b. Time o					28d. Describ			ocity)	
o 1 Natural 5 Pending (Month, Day Year) Injury						28c. injur Wor	k? Yes 2[
rtiflcation:	2 Accident investigat 3 Suicide 6 Could not	be 390 Place of Ir	sium, At ho	me fam at	M factor				28f Location	(Street and	d Number a	Rural Route M:-	hor
Ē	4 Homicide determine	building, e	itc. (Specify	y)	trm, street, factory, office 28f. Location (Street and Num City or Town, State))	· idiai · iodie ivum	DO1,	

State Registrar

29a. Certifier

29b. Signature and title of certifier

ress of person who completed cause of death (Item 23a) (Type, Pnnt)

30) Hospital Deve,

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

August

21061.

6 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 2048 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba HOPKINS MHOC Hospital If Under 1 Year Date of Birth (Month, Day, Year 2-17-45 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Min. 1**X**M 2□F Days 217-40-3158 59 Director Baltimore, Md Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a State 10b. Count 10c. City, Town or Location 28a-f show Examiner must be notified at Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 2411 Mcelderry St. 21205USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should ba filed within 72 hours affer on and Mental Hygiene. Is marked other than "natural" or Iten 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo ģ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Cab Driver Cab Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Faison Sr. 2 James Genevieve Faison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 Harrietta Alexander Frined 2411 McElderry St. Baltimore, Md. 21205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State parmit. Pages 1 Department of H Important: If ites any injury or ott 1 XBurial 2 Cremation 3 Removal from State Western Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 8-13-04 Baltimore Md. 22. Name and Address of Facility
Estep Brothers Funeral Ser.P.A.
1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee Estep Brothers Funeral S 1300 Eutaw Place, Baltimo 23a. Part. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CANDIDEMIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transit The law requires that the death certificate be executed the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A М 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Lasanta Horana

31. Date filed (Month,

RES-000

Johns Hopkins Hospital Goo North Woife Street, Baltimore Maryland

& an Hedical Poctor

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		4	For State Registrar	tate of Maryla		rtment of H		dental Hygier Reg.				
- · ·	Physici		1. Decedent's Name (First, Middle, Last) 2. D						Death T 4, Day 2004 Year 10:15p M			
)	/Medic Examin		4a. Facility Name (If not institution, give stre 1507 N. APPLETON	4b. City, Town, or BALT1	Location of Death		4c. County of Death	-				
%. %. :	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs 2	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 11-27-19	9. Birthr	place (State or Foreign http:// TH CAROLINA		
e, Maryland 2	wode I	or	Usual Residence of Decedent 10a. State 10b. County MD • N/A		ity, Town or Loc					10d. Inside City Limits		
	with the Na or 28a-	I Director	10e. Street and Number 1507 N. APPLETON	ST.		10f. Zip Code 21217	7	10g.	10g. Citizen of What Country? USA			
	within 72 hours after death with the Marylan idea. idea. Itan. naturel; or itams 23s or 28s-1 show the Medical Examiner must be inclifted at	by Funeral	TT. Marital Otalas	Was Decedent Ever in Armed Forces? 1 _Yes _257 No ff Yes, Give A Year or Dates:	- 11	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.		
	within 72 hours after ene. then "naturel", or its he Medical Examine	Completed b	15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)	on	lent's Usuaf Occupa kind of work done of OO NOT use retired	ation during most of world)	16b	16b. Kind of Business/Industry				
	be filed tat Hyg d othe event,	To Be Cor	-12- 17. Father's Name (First, Middle, Last) ROBERT FISHER	-0- CLERK 18. Mother's Name (First, Middle, M ELIZABETH McCHO								
	nd 2 should th and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type, DEBORAH ALFORD (N					BALTIMORI		1		
	nit. Pages 1 and artment of Healt ortant: If Item 2: Injury or other 1		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Cocation - City or Town, State 20c. C									
Balt	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Licensea JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. PALTIMORE, MARYLAND 21217									
‡ 114€ 1	hysician		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate finterval Between Onset and Death Immediate Cause (Final disease or condition a. Cerebrovescular accrident 3 years.									
vision of Vital Records, P.O. Box 68760,	/Medical Examiner		Due to (or as a consequence of):									
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	that the death ed by the atten detached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						Month Day Year		
	w requires that s been signed to should be deta	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to							the cause of death?		
	The law re cate has bee page 2 sho	Completed	Hypertension					24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No			
	Physician: The I rthis certificate ha ral director, page	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	6 Other (Specify)								
	To the Hospitel or Attending Ph within Z4 hours after death. To the Funerel Director: After th completely filled in by the funeral	atlon:	27. Manner of Death 1 Naturaf 5 ☐ Pending 2 ☐ Accident investigation	28b. Time of fnjury	M 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			be how injury occurred				
	tel or Att	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or a City or Town, State)							al Route Number,		
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)	To the within 2 To the complet	Σ	29b. Signature and title of centiller	De hum	60	29c. Licens	O223	29d.	Date signed (Month)	, Day, Year)		
/			30. Name and address of person who com	pleted cause of death (In	em 23a) (Type,			woods.	Il too			
46	St Regist	ate trar	31. Date filed (Month, Day, Year)	82. Registrar's Sig	nature	books						

DHMH 17 Rev 1/2001

			1- For Amend Item 1 Registrar 22, per DV	State of Mai 9b per FH,	yland / Depa 3834, 08/2	rimen 104di titicate	t of H	ealth a Death	ınd M		giene Reg. No	٦١,	25221.	
	Physici	an	Decedent's Name (First, Middle, Last) LEONARD			FEINROTH			2. Date of Death Month 7 9, 2004		Year	7:00 P M		
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death			A00031	4c. County		7.00 F ···		
			SUNRISE ASSISTED LIVING			PIKESVILLE					BALTIMORE			
	Funeral Director		5. Social Security Number 6. Sec. 110-09-3519	7. Age X M 2□F	(In yrs. last birthday) 89 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bird Month, Da JULY 2	1,1915	9. Birthi Cou	place (State or Foreign ntry) NY	
	pur 🛦		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation								
	the Maryland r 28a-f show	tor		LTIMORE	PIKES								10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	ith the or 28a	Director	10e. Street and Number			10f. Zip	Code				10g. Citizen of V	What Cou	ntry?	
	eath w	Funeral	3800 OLD COURT RO	OAD 12. Was Decedent Ev	er in IIS 12 1	Mac Daned		21208		naifu Van ar Na	14 Pag	a Amari	USA can Indian,	
980	72 hours after death with the Maryland 'naturel', or items 23a or 28a-f show Alteal Examiliser must be multified at	by	1 Never Married 2 Married 3 Midowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, spec			, Puerto	ecify Yes or No Rican, etc.)	Specify	ck, White,		
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2121	filed within I Hygiene. other than "	ompl	Elementary/Secondary (0-12)	College (1-4or 5+)	HEALT						U.S. G	OVERN	IMENT	
nd	Hyg othe	Be	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Suman	10)		
Maryland 2121	2 should be and Mental Is marked ore	ပ္	MORRIS 19a. Informant's Name/Relationship (7	ivna Printl	FEINR		/Street o	EMM		I Boute thombs	er, City or Town,	C4-4- 7/-	BRASS	
	as 1 and of Health fitem 27 r other to		ALICE HELLER / DA		3306						ILLE, MI		,	
Baltimore,			20a. Method of Disposition 1 🕱 Burial 2 □ Cremation 3 □		20b. Place of Dispo	natory or of	her place	·		oate (OOO)	20c. Location -			
altin	permit. Pag Department Important: I eny injury o		4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License		HEBREW YO						WOODI SON & BR			
ä	Per Per Per Per Per Per Per Per Per Per	1 11	Potebla		75	yuu ki	-1211	ERSIO	MN K	UAD - F	IKEZAIL	LE,	MD 21208	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a											
8760,	e be executed sician and purial-transit	er	Sequentially list conditions, if any, leading to immediate b. AZNPIMPUS WISUS Due to (or as a consequence of):							Tylay				
		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
9	ta de de	Medic	IF FEMALE:	d										
.O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Fetal death 4 Pregnant at time of death 9 Unknown 23c. If yes, outcome of pregnancy 1 Cive birth 2 Fetal death 4 Pregnant at time of death 9 Unknown								23d. Date of delivery Month Day Year			
rds, P		by	Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.								for tobacco use contribute to the cause of death? Yes 2 700 3 Probably 4 Unknown			
Vital Records,		Completed									rmed?	Were auto prior to co- death?	psy findings available mpletion of cause of	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	-		(Check only o			ALCICTU	
of	or Attending Physiter death. Diractor: After this in by the funeral dir	ition: To	1 Yes No No Notatient 2 ER/Outpatie 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 2 Accident				nt 3 DOA 4 Nursing Home 5 Hesidence 6 Mother (Specify)							
Division		Certification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place of Injun	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	he Hospitel n 24 hours a he Funeral I	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2 To the complete	Me	29b. Signature and the of certifier	1) 1)		29c.	License	number	_	ы	29d. Date signed	(Month,	Day, Year)	
	W		30. Name and address of person tho o	ompleted say erol dea	th (Item 23a) (Type	Print)	1) 16	304	1		6-10	HUY		
	/ "		Michael Ru	d1/10/1	183 8	3 61	uppu	PTYP	PRI	d Bo	altum	D 9	1208	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2004	32. Registrar	s signature	par	2							

DHMH 17 Rev 1/2001

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic evant, I'm Medical Exemitational by mailined at once. Tuesdry, August 32, 2004 @ SYOPM Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, 1740 GERST, HAZEL 08-03-04@

Physician /Medical Examiner

Physician /Medical **Examiner**

To Be Completed by Funeral Director

Funeral Director

Please 1	Type or Print in Black I	ndelible lnk End	sure All Conies A	re l egible
	State of Maryland / Dep			_
1 - State Registrar		ertificate of Deat	h	NGO O O O O O O
Decedent's Name (First, Middle, Last)	· - C		2. Date of Death Month	Day Year (3. Time of Death)
HAZEL BEL	LE GERSI		AUGUST	3 2004 5:40 PM
4a. Facility Name (If not institution, give	CEN (TED	4b. City, Town, or Location	on of Death	4c. County of Death
5. Social Security Number 6. Sec			ler 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign
011-04-1000	M 2004 80 Yrs.	Months Days Hours	s Min. (Month, Day Y	24 WEST VIRGINIA
Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
MD BALTH	MORE SPAR	2KS		1 ☐ Yes 2 No
10e. Street and Number	4.0	10f. Zip Code	10g.	. Citizen of What Country?
16626 CEDAR	GROVE KD.	121152	U	VITED STATES
11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	 Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
3 Widowed 4 □ Divorced	If Yes, Give Year or Oates:	1 ☐ Yes 2 No Speci	ty:	Specify: WHITE
15. Decedent's Edu (Specify only highest grad	le completed) (Gir	cedent's Usual Occupation we kind of work done during m	ost of working	b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	¥.	OOD GERLIGER
17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middle, Mai	iden Sumame)
UNKNOW	n Foxx		UNKNOU)N
19a. Informant's Name/Relationship (T)	pe, Print) 19b. Ma	iling Address (Street and Nun	nber or Rural Route Number, C	ity or Town, State, Zip Code)
20a, Method of Disposition	20b. Place of Dis	du CEDAK (position (Name of	Date CD St	C. Location - City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)	Removal from State cemetery, ci	rematory or other place)	Philas H	ALIANTE MIN
21. Signa ut at meral Service Liceo	1 40/1/01/1	22. Name and Address of Fac	oj4t04 FII	anover, IIID
XXX et			Funeral Home And Cremation Road - Pasadena, MD	
23a. Part1. Enter the disease, or compositions shock, or heart failure. List only of	ications that caused the death. Do not e			, Approximate Interval Between
Immediate Cause (Final disease or condition	undisterer	it inted new	No ectodorn	onset and Death Onset and Death
resulting in death)	Due to (or as a consequence of):			
Sequentially its conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):			
cause. Enter Underlying Cause (Disease or injury that initiated events				
resulting in death) Last	Due to (or as a consequence of):			
	J			
IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of delivery
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 Fetal death 3	B □Ectopic pregnancy □ Other (specify)		Month Day Year
9 Unknown	9 Unknown			
Part II. Other significant conditions co.	ntributing to death but not resulting in the	underlying cause given in Pa		co use contribute to the cause of death?
			1 Tes	2 No 3 Probably 4 Unknown
			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
			performed	d? death? No 1 Yes 2 No
25. Was case referred to medical examiner? 1 \sum Yes 2\sum No	Hospital:	Other	ace of Death (Check only one) Nursing Home 5 ☐ Residence	e 6 Dother (Specify) Has Al Ce
27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe how	7
1 Natural 5 Pending 2 Accident investigation	(Monar, Day 1 ear) Injury	M 1 ☐ Yes 2	□No	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	it and Number or Rural Route Number, State)
2ya. Certifier (Check only one) 2 Medical Exami	sician: To the best of my knowledge, de ner: On the basis of examination and/or and manner stated.	ath occurred at the time, date investigation, in my opinion, d	and place, and due to the caus eath occurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of pertifier	10	29c. License numbe	er 29d.	Date signed (Month, Day, Year)
I Al thish	y they me	10250	05 19	Lugust 4, 200x
30. Name and andress of person who co	omic leted cause the in (Item 23a) (Typ	e, Print)	, 00.	md 2(20)
31. Date filed (Month, Day, Year)	G Sonc 6701 /	F. Charles J	to salto.	ma 4 20 %
J. Date med (Monut, Day, 18ar)	32. Registrar's Signature			

Registrar DHMH 17 Rev 1/2001

State

AUG 1 2 2004

Medicai Certification; To Be Completed by Physician/Medicai Examiner

within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

> God ORIGINAL

D	OS		1- For Amend Item 22 per FH, 6834,08	partment of Health a	nd Mental Hy	rgiene
F	Physicia	an	Decedent's Name (First, Middle, Last)	oranicate or beauti	2. Date of De Month	
	/Medic		Robert Lynn Helmick		July	1, 2004 1112 a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 1400 #4 Philadelphia Avenue	4b. City, Town, or Location of Aberdeen	Death	4c. County of Death Harford
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 219-52-7017 10X M 2 F 53 Yrs.	y) If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of Bi	orth av Year 25, 1950 West Virginia
	nryland show	_	Usual Residence of Decedent			10d. Inside City Limits
	8e-f	ecto	Aberu Aberu			1 □Yes 2XINo
	with the	Dir	1400 Philadelphia Avenue #4	10f. Zip Code		10g. Citizen of What Country?
	eath v	erai		21001	in2 (Chapity Vac or N	USA o- 14. Race - American Indian,
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show tha Modical Expedient must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify: 	Puerto Rican, etc.)	Black, White, etc. Specify: White
21215-0036	2 hou	ted	15. Decedent's Education 16a Dec	edent's Usual Occupation		16b. Kind of Business/Industry
215	hin 7.	Completed	(Specify only highest grade completed) (Gi Elementary/Secondary (0·12) College (1·4or5+)	re kind of work done during most DO NOT use retired)	of working	
2	ad wit	Con	Elementary/Secondary (0-12) College (1-4or 5+)	dry wall instal	ler	construction
pu	d oth	Be (17. Father's Name (First, Middle, Last)		's Name (First, Middle	
yla	ould by Ment arked	To	Arthur P. Helmick	W	anda Mitte	r
Maryland	nd 2 sh alth and 27 Is m r traum			iling Address <i>(Street and Number</i> 47 W. Chapel Roa		ner, City or Town, State, Zip Code)
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Executer must be notified at once.			position (Name of rematory or other place)	Date	20c. Location - City or Town, State
Balti	permit. Departm Importa any inju		21. Sinature of Ronald Service licensee Ronald Service Wade firector	Name and Address of Facility	212014110	pdrerm by delect
8760,	/Medical Examiner bhysician and bhysician sthe burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Intoxicati	on	Onset and Death
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		□ Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	quires that n signed t	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		tobacco use contribute to the cause of death? Yes 2 \(\sum \) No 3 \(\) Probably 4 \(\) Unknown
Division of Vital Records,		e Completed	25. Was case referred to medical		1 X Yes	psy prior to completion of cause of death? 2 □ No 1 □ res 2 □ No
5	Physician: r this certifica ral director, I	OB	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other	of Death (Check only	one) idence 6x10ther(Specify) at scene
on of	ting Afte fune	1	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time 1 Natural 5 Pending Month, Day Year)	of 28c. Injury at Work?	28d. Describe	how injury occurred
Divisi	I or Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 5 Could not be determined 4 Homicide 4 determined 4 Homicide 4 H	2011	28f. Location (City or To	(Street and Number or Rural Route Number, win, State) 14605. Philadulphia hubbardeen MD
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and investigation, in my opinion, death	place, and due to the	cause(s) and manner as stated.
,	To the within To the comple	Me	29b. Signature and title of certifier Word Hallan Ma	29c. License number OCME		29c. Date signed (Month, Day, Year) July 2, 2004
	i		30. Name and address of person who completed cause of death (Item 23a) (Type	^{e, Print)} 111 Penn Sta	reet, Balt	imore, Maryland 21201
	Sta Registr		31 Date filed (Month, Day Year) 432 Registrar's Signature	Sparks		

JD	1 - For Unpend Item #23a, pt. 1	Tyland / Depa T ,27 per m Cei	etmant of Jealth and A tificate of Death	ental Hygier Reg. 1		25327			
Physician	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death			
/Medical	William Haskins		th O'r Town and and a 1D at	July 08,	2004	0249A. M			
Examiner	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital		4b. City, Town, or Location of Death Baltimore		4c. County of Death				
Funeral Director		(In yrs. last birthday) 46 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Nov 18, 1	9. Birth Cou	place (State or Foreign ntry) unk			
pu s	Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	cation			10d Inside Obstant			
ith the Marylar or 28a-f show a notified at	MD	Baltin				10d. Inside City Limits 1 Yes 2 □ No			
r 28a- notifi	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?			
th with	2225 N. Charles Street		21218		USA				
5-0036 72 hours after death with the Maryland natural; or Items 23a or 28a-1 show dical Examinar must be notified at eted by Funeral Director	11. Marital Status unk 12. Was Decedent B Armed Forces? 1 Yes 2 N 1 Yes, Give	o unk	Nas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.			
5-0036 72 hours all natural; or dical Exam	3 U Widowed 4 U Divorced Year or Dates:	16a. Deced	lent's Usual Occupation	ing unk 16b.	Specify: b1a	ducto			
21215-00 led within 72 hor ygiene natura her than "natura it, the Medical. Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5 unk	life. I	kind of work done during most of work 30 NOT use retired)	ing GIR		unk			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. "ratural", or items 23a or 28a-1 show important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Martical Examinat must be notified at once. To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		unk 18. Mother's Name	e (First, Middle, Maid	en Sumame)	unk			
lary	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Run		y or Town, State, Zip	Code)			
B, N l and lealth im 27 her tr	O.C.M.E.				21201				
Baltimore, sermit. Pages 1 ar Department of Hea Department of Hea mportant: if item any injury or other page.	Method of Disposition Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 Donation 5 (Other (Specify) in state 5 (Other (Specify) in state 10 (Other								
Bali permit Depar impor any in	21. Productive of Funeral Selvice Licensee		Name and Address of Facility Tate Anatomy Board Telmore, MD 2120	1 ⁶⁵⁵ W. Ba	altimore S	Street			
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) Meningit Due to (or as a	e. -	er the mode of dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death			
icate be executed physician and sine burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a Due to (or a) Due to (or a) Due to (or a) Due t								
vision of Vital Records, P.O. Box 6876. Attending Physician: The law requires that the death certificate be refearly. After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the build reference of the completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Ectopic pregnancy Other (specify)		23d. Date of delive Month	,				
ds, P irres that signed to d be deta	Part II. Other significant conditions contributing to death but Hypertensive atheroscleroti			23e. Did tobacco	use contribute to the	. 1			
Division of Vital Records, to Attending Physician: The law requires that edeath. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by				24a. Was an autopsy performed?	24b. Were auto prior to con death?	psy findings available mpletion of cause of 2 No			
Vita	25. Was case referred to medical examiner? X Yes 2 □ No Hospital: 1 □ Inpatie		O++	Check onl one					
ion of \nding Physi thi. "After this of tuneral direction; To atlon; To	Yes 2 No 10 Inpatiel 27. Manner of Death 1 XNatural 5 Pending (Month, Day 2 Accident investigation	v 28b. Time of	4 Nursing Ho	me 5 Residence 28d. Describe how inj		y)			
in Pirit	2 Cuiside 6 Could not be	ry - At home, farm, stre . (Specily)	eet, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rura ite)	d Route Number,			
To the Hospital Within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifier 1 ☐ Certifying Physician: To the best of cone) 1 ☐ Medical Exeminer: On the basis of and manner sta	examination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause(ed at the time, date a	(s) and manner as st nd place, and due to	tated. the cause(s)			
To the within To the company	29b. Signature and title of certifier		29c. License number O.C.M.E.		to ate signed (Month, $1 + 2004$)	-			
	30. Name and address of person who completed cause of de	_	Print) 111 Penn Stree	t, Baltimo	ore, Mary	land 21201			
State Registrar		r's Signature	ball						

			For State Registrar	State of Maryland	/ Depa	artment o		nd Mental Hy		2001	25328
	Physici /Medic		1. Decedent's Name (First, Middle, Last, ETHEL ELIZA					2. Date of D Month August	Da		3. Time of Death 1:45 p. M
	Examin		4a. Facility Name (If not institution, give 419 Croydon Roa			4b. City, Tow Balti	n, or Location of C	Death	40	. County of Dea	
	Funeral Director		217 00 4741	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Yo Months Da		Hrs. 8. Date of B (Month, D April	irth ay Year 10,	9. Bird 1919 Mar	thplace (State or Foreign buntry) Cyland
	Maryland f show	tor	Usual Residence of Decedent	10c. City, T	own or Lo ltimo		-				10d. Inside City Limits
	a or 28a	Funeral Director	10e. Street and Number 419 Croydon Road			10f. Zip Coo			_	itizen of What Co	
036	hin 72 hours after death with the Maryland Ba "naturel", or Itams 23a or 28a-f show Medical Epanding must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1		of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or N Puerto Rican, etc.)	_	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	s within jiene. r than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation 1 e completed) College (1-4or 5+)	(Give	dent's Usual Oo kind of work do DO NOT use re	one during most of tired)	f working	16b. K	Own Hon	,
yland 2	o a a	To Be C	17. Father's Name (First, Middle, Last) Edward Allen Und				18. Mother's	Name (First, Middle on Elizabe	eth I	n Sumame) Rowe	
	1 and 2 s Health ar em 27 is ether trau		John O.L. Hauser (H	usband)	419 (Road Ba	or Rural Route Numb 1timore, M Date	aryl		12
Baltimore,	permit. Pages Department of I Important: If it any Injury or o once.		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens	Lorn	aine	Park	ddress of Facility	-12-04 feld F.H. Baltimor	Tnc	Carrier In Microsophia	,Maryland
3	Physician /Medical Examiner pur unitransit	Examiner	if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury		nce of):	er the mode of	dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between Criset and Death 3 MoNTM!
P.O. Box 68760,	it the death certificate by the attending phys tached for use as the	Physician/Medical	IF FEMALE:	d	ath 3]Ectopic pregn] Other <i>(specif</i>)				23d. Date of del Month	ivery Day Year
Records, I	n requires that been signed should be de	by	Part II. Other significant conditions co	ntributing to death but not resultii	ng in the u	nderlying cause	given in Part I.				o the cause of death?
al Reco		Completed						24a. Wa auto per 1 🗆 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of 2 \sum No
of Vital	Physician: Th this certificate al director, pag	: To Be	25. Was case referred to medical examiner? 1 Yes	1	VOutpatier		Other	Death (Check only ing Home 5 Pes	idence		cify)
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	1 Matural 5 Pending investigation 3 Suicide 4 Homicide 5 Pending determined	28e. Place of Injury - At home building, etc. (Specify)	Injury	М	Work? 1 ☐ Yes 2 ☐ No		(Street a	nd Number or Ri	ural Route Number,
	re Hospita 124 hours 16 Funeral Istely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	edge, deati	h occurred at the vestigation, in r	ne time, date and p my opinion, death	place, and due to the occurred at the time	e cause(s	s) and manner as id place, and due	s stated. to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier			29c. Li	D27	730	29d. Da	Plant (Mont	y. Day, Year)
	4		30. Name and address of person who of	V.MD. 65	79	N. Co	ianies.	11. B.	AT.	MINE,	70 21204
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) ALIG 1 2 2004	32. Registrar's Signatur	4	low					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 6, **Physician** 2004 ISABELLE TEWES HENNING 11:48AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pickersqill Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 13, 1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 21 X Days Hours Min. Yrs. Director 212-07-0890 88 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. Count 10d. Inside City Limits "natural", or Items 23a or 28a-f ehow 1 Tes 2 Who Funeral Director Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 615 Chestnut Avenue USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XIXto If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hyglene. Importent: If Item 27 Ie marked other then "natural", or Iten any njury or other traumetic event. Its Medical Examinat ODGs. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: þ Specify: X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Arthur Tewes Isabelle Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodger C Henning Son 623 Sussex Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Saters Cemetery 8/9/04 Brooklandville MD ☐ Donation 5 ☐ Other (Specify) gnature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Dailure TO thrive Physician disease or condition resulting in death) month /Medical Due to (or as a consequence of): Examiner venal hronic Sequentially list conditions, tany, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sician and e burial-transit The law requires that the death certificate be executed ureteral that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. for OUAVIM CANCER Physician/Medical phys ; the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2∏ No 2X No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident М 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only

707

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GBMC

32. Registrar's Signatyre

mo

6701

29c. License number

20626

arles St

29d. Date signed (Month, Day, Year)

Balto Md 21204

Division of Vital Records, P.O. Box 68760,	
Division of Vital Records, P.O. Box	68760,
Division of Vital Records, P.O.	Вох
Division of Vital Records,	P.0.
Division of Vital	Records,
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	Division

		. For	-	aryland / De	partment of I	Health and M	-	Are Legible. iene		
		1 - State Registrar		C	ertificate of	Death	R	eg. No. U 0 4	25330	
Physicia /Medic		Decedent's Name (First, Middle, Las Rosalyn Hauptscl					2. Date of Deat Month August	Day Year 10, 2004	3. Time of Death 8:55P M	
Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death		4c. County of Dea		
		Casey House			Rockvi			Montgomery		
Funeral Director		122-20-3142	7. Age	e (In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/18/1	9. Bi 929 Nev	rthplace (State or Foreign Jountry) VYork	
show	٥٢	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or					10d. Inside City Limits 12 Yes 2 □ No	
the N	Director	Maryland Montgome 10e. Street and Number	ery	Potomac	10f. Zip Code		1	0g. Citizen of What C		
th with		7912 Lakenheath Wa	ay		208	54		U.S.A.		
be filed within 72 hours after death with the Maryland tall Hygiene. Additional of other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give		3. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
72 hours "natural",		15. Decedent's Ed	Year or Dates:	16a. Dec	cedent's Usual Occur	pation		WI 16b. Kind of Business	nite	
	Completed	(Specify only highest grad		+)	cedent's Usual Occup ve kind of work done o. DO NOT use retire omemaker	during most of work d)		Domestic	villuustiy	
filed Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	Maiden Surname)		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	ToB	Morris Chapnic	K			Mo11y	Rosenb	erg		
2 sho and is m		19a. Informant's Name/Relationship (7	, ,					City or Town, State,	Zip Code)	
1 and Health em 27 ither tr		Mindy Lynne Raphae 20a. Method of Disposition	el/daughte		2 Lakenhe			MD 20854 20c. Location - City or	Town State	
permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		1 ■ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify		cemetery, c	rematory or other pla	ce)				
permit. P Departme Importar any injur		21. Signature of Funeral Service Ligen			rk Cemete 22. Name and Addre			Emerson, N	4J	
		Jan 4. Will	0						lng, MD 20904	
Physician /Medical Examiner parish transit prints Physician and pr	Examiner	23a. 2a. 1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Parkins Due to (or as a	on s Dise a consequence of): a consequence of):					Interval Between Onset and Death	
The law requires that the death certificate be entered to the law requires that the death certificate be entered to the state of the bear signed by the attending physician page 2 should be detached for use as the buria	Physician/Medical E	IE FEMALE:	d	of pregnancy 2 Fetal death 3	3 ⊟Ectopic pregnanc 5 □ Other (specify)	y		23d. Date of de Month	livery Day Year	
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The law requir sate has been si page 2 should	Completed						24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of	
ician: certifica ector, p	BeC	25. Was case referred to medical examiner?				26. Place of Death			2210	
ng Phys fter this	ation: To	1 yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatied 28a. Date of Injur (Month, Day		of 28c. Injur	4 Indising Ho	me 5 Reside 28d. Describe ho	nce 6 Other (Spe w injury occurred	Rospice	
al or Atte s after de l Directo d in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	iry - At home, farm, (Specify)	street, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,	
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely tilled in by the tu	edicai (29a. Certifier ↑ Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examination and/or	ath occurred at the til investigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	s stated. to the cause(s)	
To t withi To t	Σ	29b. Signature and title of certifier	free		29c. Licens MD424			Od. Date signed (Mont August 11,		
O		30. Name and address of passen who co	ono1 1911	1 Drines		. #327	Olney, M	D 20832		
Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature	Philip Dr	uksi				
Registr	ar	AUG 1 2	2004	,	/ //					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Aug 8, 2004 **Physician** 9:24 PM. M Beatrice M. Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Pasadena 8335 Catherine Ave | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Dec 30, 1924 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 F 218-16-2587 79 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Yes 2 No Anne Arundel Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8335 Catherine Ave 21122 items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 6 1 ☐ Yes 2 ☐ Yoo Specify: Black If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event, ILE ME ODGS. Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 90 Violette J. Murdock William H Murdock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8335 Catherine Ave Pasadena, Maryland 21122 Ann Hall altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/13/04 Pasadena, Maryland Mt Zion Church Cem * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Home P.A.
1300 Eutaw Place Baltimore, MD 21217 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner The law requires that the death certificate be executed the burial-transit Box 68760, physicien use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown jo Day 5 Other (specify) P.O. I the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be lar 1 ☐ Yes 2 No 3 Probably 4 DUnknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 2 → No 24a. Was an has autopsy performe Yes 2 certificate Cerebrovascular 1 Tes or Attending Physicien: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)
t 28d. Describe how injury occurred 1 🗌 Yes Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28c. Injury at Work? After Injury 5 Pending 1 Yes 2 No death. investigation within 24 hours after death To the Funerel Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 🗌 Homicide filled To the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ghway \$204 melevi. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 3, 2004 August 1:30 Holmes Hortense B. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner (Home) Baltimore 1121 St.Agnes Lane If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9-23-24 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Baltimore, Md Months 1 ☐ M 2 💢 F 79 215-14-8494 Director Usuel Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County 28a-f show other traumatic event, the Medical Examinar must be notified at 1X Yes 2 □ No Director Baltimore Md. N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21207 USA or Items 23a 1121 St. Agnes Lane. permit. Pages 1 and 2 should be filed within 72 hours after death be partment of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a any injury or other traumation. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X☐ No Specify: Black Maryland 21215-0036 Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) St. Agnes Hospital Housekeeper Dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2131 St.Luke Lane,Baltimore,Maryland 21207 Rev.Zollie Bagby Friend altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8-10-04 Garrison Forest Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) Estep Brothers Funeral Ser, P.A. 1300 Eutaw Place, Baltimore, Md. 21. Signature of Funeral Service Licensee Estep Brother's Funeral 300 Eutaw Place, Baltimo 1300 Eutaw Place, Baltimo 1300 Entaw Place, Bal 21217 Approximate Interval Between Onset and Death INFARCTION Immediate Cause (Final disease or condition resulting in death) MYCCARDIAL **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): -burial-Box 68760. ician Physician/Medical phys the t as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death esn 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) P.O. ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 Yes 2 No 3 Probably 4 Monknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner?

1 ★ Yes 2 No 26. Place of Death (Check only one, Be Other: 4 \(\) Nursing Home 5 \(\)Residence 6 \(\)Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Diractor: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check on one) 29d Date/signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier war MD 2004 Desec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), CHALLES ST TOWSON MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG1 2 Registrar

			1 - For State Registrar		State o	f Mary	land / Der <i>Ce</i>	artmer			ind M		Reg. No	13 (3)	25333	
	Physici	an	1. Decedent's Name (First, Midd E1sie	le, Last)	Hea	n d						2. Date of De		^y 2004 ^{Year}	3. Time of Death 8:20 a M	
	/Medic	al	4a. Fecility Name (If not institution					Ab Cib	Town or	Location o		August	-	. County of Death	0.20 a M	_
	Examin	er	Manor Care-Ro			moe.)		1	lossv		, Dogui		1	Baltimore		
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birthda		r 1 Year	If Under 2	24 Hrs. Min.	8. Date of Bir				-
	Director		243-22-1491	1 🗆 1	M 2∏ F	79	Yrs.	Months	Days	Hours	MIII.	March	21,1	.925 Nort	lece (State or Foreign try) n Carolina	ί
	and w		Usual Residence of Decedent 10a. State 10b. Count	,		10	c. City, Town or	Location						11	Od. Inside City Limits	_
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	r 28a	Director	10e. Street and Number					10f. Z	p Code				10g. Cit	tizen of What Coun	try?	
	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show avent, the Medical Examinational be motified at	aiD	2825 Lodge F	arm F	Road	102				2121	L9		Un	ited Sta	tes	
	ems er m	Funerai	11. Marital Status		2. Was Dec Armed F	orces?	in U.S. 13	. Was Dece If Yes, spe	dent of Hi	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White,		
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σ Σ	2 2 3		Mrs. Carolyn			ghter								Maryland	21122	
ē,	s 1 and if Health Item 27 other to		20a. Method of Disposition			2	Ob. Place of Dis	position (Na	me of	e)	C	Date	20c. L	ocation - City or To	wn, State	_
Ë	@ O		*¥X8urial 2 ☐ Cremation * 4 ☐ Donation _5 ☐ Other (moval from	State	Holly H		-		8/13	3/2004	М	iddle Ri	ver, MD	
Baltimore,	permit. Page Department Important: If any Injury o		21. Signature of Suneral Service	License	0	1)				-			Dund	alk,Inc.		1
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x 68760,	leath certificate be executed attending physician and I for use as the burial-transit	/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	d.	Due to		onsequence of):							23d. Date of delive	rv.	_
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rds, P.	The law requires that the death certifica tte has been signed by the attending ph tage 2 should be detached for use as th	ed by PI	Part II. Other significant condit	ions cont	-		ot resulting in the		cause give	en in Part I.				use contribute to th	e cause of death? ably 4 Monknown	
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0	b		30. Name and address of person		. 0	se of death			2009	mie	-	nD ND		1061		
	Sta Registi		31. Date filed (Month, Day, Yea, AUG 1		32. F	Registrar's	Signature	,	par			· •				

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						Certino	ate of Death	2. Date of Death	g. Nø. []	3. Time of Death
		Physici	an	Decedent's Name (First, Middle, Last)				Month	Day Y	/ear
		/Medic		Florence E		45	City, Town, or Location of D	<u> </u>	8 204 4c. County of	
		Examin	er	4a. Facility Name (If not institution, give s			Glen Burn	ie.	Anne	
		F		5. Social Security Number 6. Sex		, -(nder 1 Year If Under 24 I	Hrs. 8. Date of Birth		
		Funeral Director			153 -	90 Yrs. Mor	ths Days Hours N	June 02	1914	9. Birthplace (State or Foreign Country) MD
				Usual Residence of Decedent				1000		110
		rylan how		10a. State 10b. County		City, Town or Location				10d. Inside City Limits
		Be-1 s	Funerai Director	Maryland Anne Ar	runder		Baltimore			1 ☐ Yes 2 X No
		iff the	Dir.	10e. Street and Number		10	f. Zip Code	10	g. Citizen of Wh	
(1)		23a	rai	6700 Ft. Smallwoo			21226		USA	·
3		er de	nne	Tr. Waltar Glatag	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was D	ecedent of Hispanic Origin? specify Cuban, Mexican, Po	' (Specify Yes or No- uerto Rican, etc.)		- American Indian, . White, etc.
5	36	rs aft	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 🗆 Y	es 2⊠ No Specify:		Specify:	White
Florence	Ö	ture F	edi	15. Decedent's Edu		16a. Decedent's	Usual Occupation		6b. Kind of Busi	ness/Industry
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	פ	e file al Hys othe vent,	BeC	17. Father's Name (First, Middle, Last)	-		18. Mother's	Name (First, Middle, M	taiden Surname)	
5	<u>lar</u>	uld b Venta rrked rific •	ToE	Peter W.	Moran		Etta	Bosley	4	
Jubb,	ar	sho and I		19a. Informant's Name/Relationship (Ty	, . ,		fress (Street and Number of			
5	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other then "neturel", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinar must be natified at addes.		Linda C. DiPaula		Val	ress Road, S			
,	ore	ges 1 of H if ite		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F		Place of Disposition cemetery, crematory		ug. II		ity or Town, State
	Ë	Pag ment tant: jury o		' 4 ☐ Donation 5 ☐ Other (Specify)	G		Cemetery	2004 (Glen Bur	nie, Maryland
	3all	permit Depart Impor any in		21. Signatur of Funeral Service License	88/ L.A		ne and Address of Facility			Home, P.A.
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		uted	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events						
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	Records,	neen hould	Completed					-		
	3ec	S S	mpi					 24a. Was an autopsy perform 	pric	ere autopsy findings available or to completion of cause of ath?
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6	Vital	Physicien: The law this certificate has E ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only one		10
	of	Phy alc	٠ <u>٠</u>	1 Yes 2 No	28a. Date of Injury	ER/Outpatient 3[28b. Time of	28c. Injury at Work?	g Home 5 Resider		
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	Ö	el or s afte al Dir	ert	4 [] Hornicide	building, etc. (Spe	city)		City of Town,	State)	
		To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page					irred at the time, date and plation, in my opinion, death o			
		the H in 24 the Fi	edical	(one)	and manner stated.	TIALION AND INVESTIG				``
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)		30. Name and address of person who co			8	0	2	8,2004 WD 20904
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State of Maryland / Department of Health and Mental Hygiene

				_		Certificate of	Death		Reg. No.	nI.	250	25
	Physici	an	1. Decedent's Name (First, Middle, L					2. Dete of Dea Month	ith Day	Year A	3: Time of	Death
7	/Medic		TIMOTHY	JONE	5			7	12	BH	1500)
1	Examir	ner	4a Facility Name (If not institution, g	•		4	4b. City, Town, or L		4c. County	of Death		
			Genesis Long G 5. Social Security Number 6.	reen Sex 7. Age (in yi	re lact hirt	thday) If Under 1 Year	Baltimo	ne 8. Date of Birth		O Diah	-l (Ctt-	
	Funeral Director		215-88-9573 Usual Residence of Decedent	1 M 2 □ F 3		Yrs. Months Deys	Hours Min.	Month, Dey Nov 23,	(, Year)	9. Birthp Cour	place (State o	unk
Pool	* t		10a. State 10b. County	10c.	City, Towr	or Location				1	I0d. Inside Ci	ity Limits
Men		ģ	MD	F	Balti	more					1 ▼ Yes	2 □ No
4	7.28	Director	10e. Street end Number			10f. Zip Code		1	10g. Citizen of V	Vhet Cour	ntry?	
3	230		115 E. Melrose	Avenue		2	21212		USA			
1215-0020	ors sice local with the maryer al', or Nems 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Status UT 1 Never Married 2 Married 3 Widowed 4 Divorced	1C12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	υ,s. unk	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☒ No		ecify Yes or No- Ricen, etc.)	14. Race Blace Specify	k, White,	etc. 1ack	
	iene. than "natural", the Medical Exal	g g	15. Decedent's E		16e.	Decedent's Usual Occup	ation	unk	16b. Kind of Bu	siness/Ind	dustry	unk
215	e Par	Completed	(Specify only highest gi	College (1-4or 5+)	\dashv	(Give kind of work done of life. DO NOT use retired	during most of work d)	ing				allic
2	ne gran	5		ınk								
Maryland 21215-0020	yes a sure snow as more more to the train and Mental Hygiene. If item 27 is marked other than or other traumatic event, the H	To Be	17. Father's Neme (First, Middle, Las	1)		unk	18. Mother's Name	e (First, Middle, i	Maiden Sumam	(8)		unk
ary	and Ment s marked numatic e		19a. Informant's Name/Relationship		19b.	Mailing Address (Street	and Number or Rur	el Route Numbe	r, City or Town,	Stete, Zip	Code)	
	alth a		Genesis Long Gre		1	15 E, Melro	se Avenue	Baltim	ore, MD	212	212	
ore	ant: If Itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donetion 5 ☒ Other (Special Content of the Content	□Removal from State	. Place of	Disposition (Name of y, cremetory or other place			20c. Location -			
Balt	Department Important: It any Injury o		21. Signature of Forneral Service Lice	wade, lirecto	or	22. Name and Address	ss of Facility Omy Board	655 W.	Baltimo	ore S	treet	
	_		Juneally	1 Class		Baltimore,						
	hysician		23a. Par 1. Enter the diseas for coo shock, or heart failure. List only	one cause on each line.	ath, Don	iot enter the mode of dyln	g, such es cardiac	or respiratory arr	est,		Approximate Interval Bety Onset end D	eath
	/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)	a ARUIRED	100	vac Defic	eercy S-	ind.			un know	~
		- I	Tooling III do Lily	Due to	(or as a c	consequence of):	·			1		
2	asit S	Examiner		b Cuclexic							لتملحب	-
,	n end ial-tre	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as e c	onsequence of):				İ		
68760,	sicla e bur	edicai	triat trittated events		(or es e ci	onsequence of):					Vakac	
X		2	resulting in death) Last	d	(0, 00 0 0							
Ď f	ettendii d for usa	Clar	Dad II Other elgoificant conditions	postribution to don't but and	andina in	No. or destrict a server of the	en in Dod I	90h Bidde				4 44-0
л. О. 🛔	by the eche	hys	Part II. Other significant conditions	contributing to death but not h	esuiling in	the underlying cause give	en in Parti.		obacco use con ′as 2□No	3 □ Prot		Unknown
T, 1	ned l	γ						,,,,	20 110	0_110	and the second	DIIKIIOWII
Division of Vital Records, for Attending Physician: The law requires t	s been sig	Completed by Physician/						24a. Wes a perform		ava	ere autopsy fi ailable prior to mpletion of ca death?	0
# F	age age	E						1114	65 21 No	1]Yes 2□	No
	rtifica stor, p	Be	25. Was case referred to medical				26. Place of Deat	h (Check only on	16)			
	direc	10	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	☐ ER/Out	patient 3 DOA Othe	or:	me 5□Reside		er (Specify	y)	
VISION Of VITA	ith. : After th e funaral	ation:	27. Manper of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Accident investigation	28e. Date of Injury (Month, Dey Year)	28b. Ti	ijury Worl	/ at ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurr	ed		
DIVIS	after death. Director: After to in by the funare	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		home, far	m, street, factory, office		28f. Location (St City or Town		er or Rura	I Route Numb	ber,
Hospita	4 hours Funera taly fille	edicai C	29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my kinner: On the basis of examinand manner stated.	nowledge, nation and	death occurred at the tim Vor investigation, in my op	ne, date and place, pinion, death occurr	and due to the ca	ause(s) and ma ate and place, a	nner as st and due to	ated. the cause(s))
Tothe	Vithin To the	Me.	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, i	Day, Year)	
	> - 0		· A	MD		0~~	59056		SIEIN	4		
			30. Name and address of person who		em 23e) (1		~ 4066		21210	- [
			Dallet 5 S	WIC MD	100	so west t	17 Novel	Due	R=14 1	ΛĐ	212	(7
	Sta	te	31. Date filed (Month, Day, Yeer)	32. Registrar's Sig	nature	1.						
***	Registra	ar 🕘	Aug 1 2 200	14 Donera	/S	Marin 1	•					

DHMH 16 Rav 6/95

04-05 RJ			please pend item #23a,27 - For - Stata - Registrar	State of M	arytano		artment of t rtificate of			giene Reg. No.	004	25336
			Decedent's Name (First, Middle, La	ast)	-				2. Date of De	ath	O O -4	3. Time of Death
	Physicia /Medic		DAISY MCROY	JENNINGS					August	9, Day 2	004 Year	0227 A. M
	Examin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City, Town, o	or Location of Death	1	4c. C	ounty of Deat	th
10			St. Agnes Hospita 5. Social Security Number 6.	Sex 7. Ac	o /In ure la	ast birthday	Balt If Under 1 Year	imore If Under 24 Hrs.	9 Date of Bin	th	O Rid	thplace (State or Foreign
211	Funeral Director			1□M 2X1F	48	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da 9-17-	y, Year)	Co	ountry) MD
7			Usual Residence of Decedent									
	show	ř	10a. State 10b. County			, Town or L						10d. Inside City Limits 1 X Yes 2 No
	the N	Director	MD 10e. Street and Number		BA	LTIMO	RE 10f. Zip Code			10g. Citize	en of What Co	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	Ö	1116 WHATCOAT ST	REET				217			USA	,
	death	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S	3. 13.	Was Decedent of I	Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No		I. Race - Ame Black, Whit	
36	or the	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔯 If Yes, Give			1 ☐ Yes 2 ☑ No			S	Specify:	0, 010.
21215-0036	hours tural'		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1		dent's Usual Occu			16b. Kind	BI d of Business	LACK (Industry
215	nin 72 In "na Medic	plet	(Specify only highest gi		54)	(Give	kind of work done DO NOT use retire	during most of wor	rking			
212	filed with Hygiene other tha	Completed	Liententary/decondary (0-12)	1	347	SE	CRETARY				DICAL	
nd	be filed within 72 hours ital Hygiene. Id other than "natural; event. It is Medical Ex-	Be	17. Father's Name (First, Middle, Las					18. Mother's Nar		, Maiden S	umame)	
Maryland	d 2 should be filed withir th and Mental Hygiene. 7 is marked other than traumatic event. I'm M	^L	MILTON MCROY, SR 19a. Informant's Name/Relationship			19b Maili	ng Address (Street	LAURA :		er City or	Town State	Zin Code)
Ma			LAURA MCROY/MOTH				6 WHATCOA		ALTIMORE			21217
ē,	-ISS	1 8	20a. Method of Disposition		C	ace of Disp	osition (Name of matory or other pla	1	Date		ation - City or	Town, State
7 E	<u> </u>		1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Spec				CEMETER		6-2004	BAL	TIMORE	, MARYLAND
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	ensee	4	2	2. Name and Addre	ess of Facility JA	MES A.	MORTO	N & SO	NS F.H., INC.
	20 E 9 9		23a. Parf. Enter the disease, or cor	190	JOY			AURENS ST			, MARY	
			shock, or heart failure. List only Immediate Cause (Final	y one cause on each I	ine.					rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		COMPT	icati:	ng narcot	tic intox	ication			
	Examiner				a consequ							
	LAGITATIO		O and the first and divines		a consequ							
	, X-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as		ence of):						
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		T many	水料	Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	/ Year	3. Time of Death
		Physicia /Medic	_	SHAWN D. JONE	ES, SR.					August			12:27 A.M
	7	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City	, Town, or Lo	ocation of Death	1	4c.	County of Death	1
10				Maryland General H	lospital	(In yrs. last bir	thday) If Unde	Balti er 1 Year	more f Under 24 Hrs.	8. Date of Bir	th	9. Birth	nplace (State or Foreign
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		er de	Funeral	Tr. Mariai States	2. Was Decedent E Armed Forces?		13. Was Dece	edent of Hisp ecify Cuban,	anic Origin? (S Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Amei Black, White	
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	7	iled w tygier ther th		17. Father's Name (First, Middle, Last)			DELIVER		8. Mother's Nar	ne (First, Middle			.τρ
	land	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "neturel", or liems 23e or 28e-f show le marked other than "neturel", or liems to restlike a streamfelt event, It a Modifical Examination and building at	To Be	ARTHUR ROBINSON					EVELYN	JONES			
	Maryland 21215-0036	ges 1 and 2 should be filed within 72 hc to f Health and Mental Hygiene. If item 27 is marked other than "netun or other treumetic event, it a Mudical		19a. Informant's Name/Relationship (Type CLARICE ANDREWS/AU		196	Mailing Addres			BALTIMO	ORE,	nr Town, State, Z MARYLAN	(ip Code) D 21213
	Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 li eny injury or other tre once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re	emoval from State	Sacred	f Disposition (National)	of Je	sus 08/1	Date 18/04 17-2004	22	ocation - City or	Town, State MARYLAND
	Iţin	artmer artmer ortent injury		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	0	MI Z	22. Name	and Address	of Facility J	T			NS F.H., INC.
	Ba	Deparenti Impolenti eny ir		Names a.	mort	-07	1701-	-31 LA	URENS S	r. BALT	IOMI	RE, MARY	LAND 21217
	10	S 75		23a. Parl 1. Enter the disease, or complice shock, or heart failure. List only on immediate Cause (Final	cations that caused e cause on each lin	10.		ode of dying,	such as cardia	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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	Division	or Attendi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 【Could not be determined	28e. Place of Inj			ory, office		28f Location		nd Number or Ri	ural Route Number,
	Ö	spitel or A ours after herel Dire			H	ouse				Batti	More	Mayerr	e Ave.
		Ho Fug Bely	edical	29a. Certifier 1 ☐ Certifying Physical (Check only one) 1 ☐ Certifying Physical Examination (Check only one)	ner: On the best ner: On the basis o and manner st	f examination a	nd/or investigati	on, in my opi	nion, death occ	urred at the time	, date an	d place, and due	to the cause(s)
_		To the within 2 To the complet	Me	29b. Signeture and title of certifier		00	2	29c. License	number			ate signed (Mont	
		1		Mohille	mi to	Ma	Lus	OCME			Au	gust 6,	2004
	10	+ elene,		30-Name and address of person who co	mpleted cause of	death (Item 23a)	(Type, Print)	enn St	reet, E	altimor	e, M	aryland	21201
			ate	31. Date filed (Month, Day, Year)	2. Registr	rar's Signature	1						
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 arence Dnes /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITA altimore 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 231-42-913 1 X M 2 ☐ F 69 SEPT. 12, 1934 Virginia **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Iranno any injury or other treumetic event. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 ☐ No Completed by Funeral Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 Koland 1.S.A 1ew . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life., DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MOLLY 2 inwood 19b. Mailing Address (Street and Number or Rufal Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3804 Roland View Ave. Balto. MD. 21215 Margarel Jones 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Prospect Bapt Chu, 8-12-04 Blackstone Va.
22. Name and Address of Facility Carl U. Egglesion Funeral Est. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses P.O. Box 548 Farmfille Va. 23901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) CPREDIOUNSC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1□ Yes 2□ No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 ther (Specify) NO Spice 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how in any occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 1 40854 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pari Play Riseberg, Bultimore MD 301 21202 4219 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar rence 2004 Docks!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death th 9. Birthple 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 100M 2□F Months Days Hours 216-82-1698 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 2122 VITED 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18 Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10NIA KERSE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burjal 2 ☐ Cremation 3 ☐Removal from State ANATOMY GIFTS REG 81 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signati Daugherty Family Funeral Home And Gremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 23a. Part I. Enter the disease, or complications that cause shock, or heart failure—tist only one cause—reach lie Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) HICOholism if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Cher (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho 24a. Was an autopsy 1 ☐ Yes 2 110 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Records. of Vital Division Physician /Medical

Examiner

10a. State

Funeral

Director

or 28a-f show

to Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, it is Medical Examinar in ust be notified at

Department of Important: If eny injury or

Physician /Medical

Examiner

as the

use

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signed by the a

certificate

this funeral

: After

within 24 hours after death To the Funerel Director: / completely filled in by the f

death.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

by Physiclan/Medical Examiner

Completed

To Be

Medical Certification:

the Maryland

The law requires that the death certificate be executed To the Hospitel or Attending Physician:

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 1 2 2004

Han

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

6 Could not be determined

901 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Physician Ann Marie Lee 2004 August 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick 13142 Old National Pike Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Yea March 1, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1^{Year)}1962 **Funeral** Days Months Hours Min 1 M 2 X F Maryland Yrs 265-53-2632 42 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 TtNo Maryland Frederick Mt. Airy Direct 10g. Citizen of What Country? 10e. Street and Number 13142 Old National Pike 21771 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. am 27 Is marked othar than "natural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Bone William Edgar Marcum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health an Important: If itam 27 Is any injury or other trau 13142 Old National Pike Mt. Airy, MD 21771 Husband James Edgar Lee 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State South Carroll Crematory Aug. 15, 2004 Winfield, Maryland 1 4 □ Dorfation 5 □ Other (Specify) 22. Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A 1212 W. Old Liberty Road Winfield, MD 21704 21. Signature of Funeral Service Licenses an Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate ause (Final isease condition with g in death) Presumod Cardiopulmanay **Physician** /Medical Due to (or as a consequence of) Examiner Nypartensia
Due to (o a a consequence of): Wille-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of) physician Box 68760 Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No hypothyroidism certificate has autopsy page performed' 1 ☐ Yes 2 7 No Physician: 25. Was case referred to medical 26 Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death, To tha Funaral Diractor: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8/11/04 1374887 address of person who completed cause of death (Item 23a) (Type, Print) 9093 Rageriald Divo Froderick Mc Dix leowaller Janet E. m

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 2 2004

32. Registrar's Signature

Sparks

			1 _ State	State of Maryla		artment of H			giene Reg. No:	001	05011
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath -	004	3. Time of Death
	Physicia	an	Kenneth C. Laws					Month August	7. 20)04	1:40 P M
)	/Medic Examin		4a. Facility Name (If not institution, give str	eet and number)		4b. City, Town, o	r Location of			ounty of Death	
	LXammi	٠.	Asbury Assistant L	iving		Gaither	rsburg		Mo	ntgomer	у
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. 8. Date of Bir Min. (Month, Da	th y, Year)	Cou	place (State or Foreign ntry)
١.,	Director		577-01-3347	4 2□F 9	5 Yrs.			Min. (Month, Pa April 18	3,1909	Virg	inia
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limits
	sho	5				rsburg					1 ☐ Yes 2 ☑ No
	28a-1	Directo	Maryland Montgome: 10e. Street and Number	ry	Galtine	10f. Zip Code			10g. Citize	on of What Cou	ntry?
	with Ba or	ᅙ	333 Russell Avenue	#4.O1		208	77		Unit	ed Stat	es
	ms 2:	Funeral		. Was Decedent Ever i	n U.S. 13.			in? (Specify Yes or No Puerto Rican, etc.)		Race - Ameri Black, White	ican Indian,
20	or ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 25 No		Fuelto Ricall, etc.)		San a 16	
8	rai', o	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		103 222110	Spoony.			Whi	te
2	72 h 'natu	Completed	15. Decedent's Educa (Specify only highest grade		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working	16b. Kind	d of Business/li	ndustry
121	hen o	m	Elementary/Secondary (0-12)	College (1-4or 5+)		oreman	α,		C&P	Telepho	nn e
5	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		T.	Oreman	18. Mother	's Name (First, Middle		_	,iic
and	ould be iiled within 72 hours after death with the Maryland Menial Hygiene. arked other than "natural", or items 23a or 28a-f show atto event, the Medical Exeminatment be notified at	9 Be	Ira Eugene Laws				Car	rie Weller			
Maryland 21215-0036	should and Men s marks umatic	ဥ	19a. Informant's Name/Relationship (Type	e, Print)	19b. Maili	ng Address (Street	and Number	r or Rural Route Numb	er, City or	Town, State, Zi	p Code)
<u>≅</u>	od 2 state at trau		Ida J. Laws/Wife		333 R	ussell A	venue,	#401 Gait	hersb	urg, MD	20877
ē,	of Health of Health if item 27 i		20a. Method of Disposition	20	b. Place of Dispo	osition (Name of	ce) A	Date 1.0	20c. Loca	ation - City or T	own, State
E 0	Pages nent of I int: If its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	Grema	matory or other pla itan itory					irginia
Baltimore,	1. 5 2 5		21. Signature of Buneral Service Licentee		H2	2. Name and Addre	ss of Facility	Robert A.	Pumpl	rey Fur	neral lome/ sin venue
ä	Department Department		potter for	M013	53 Be	thesda,	Maryla	nd 20814-3	501		Sierie .
13	9 6		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the concept on each line.	death. Do not en	ter the mode of dyi	ng, such as o	cardiac or respiratory a	ırrest,		Approximate Interval Between
W	Physician		Immediate Cause (Final disease or condition	ATHEROS	GERO:	MC CAP	-PIOVI	4SCULAR I	ISEA	56	Onset and Death
34	/Medical		resulting in death)	Due to (or as a cor							
Ы	Examiner		Sequentially list conditions. b.	DIABETE		-CTUS					
	pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cor	isequence of):						
	and -tran	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a cor	sequence of):						
8760,	cate be executed obysician and the burial-transit				,						
87	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical	d.								
9 x	leath certifica attending ph	/Me	IF FEMALE: 23	c. If yes, outcome of pro-					23	3d. Date of deli	very
Вох	atter	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ I		⊒Ectopic pregnanc ⊒ Other (specify) _	У			Month	Day Year
P.O.	that the de ed by the detached	Jysi	9 Unknown	9□ Unknown							
	res that the signed by th t be detache	by P	Part il. Other significant conditions conf		=				tobacco us	e contribute to	the cause of death?
rds	quire n sig uld blu	be be	PANCREATIC MA	455 PRi	ESUME	D CARCI	NOM	<u>A</u> 10	Yes 2	(No 3□Pro	bably 4 Unknown
Records,	law requires as been sign 2 should be	Completed		j				24a. Was		24b. Were aut	topsy findings available ompletion of cause of
Re	0 5 0	mo mo						perf	ormed?	death?	
Vital	ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place	of Death (Check only			
/ \	S S	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3□ DOA Ot	her: 4 Nu	rsing Home 5 🗆 Res	idence 6	□Other (Spec	eify)
n of	iding Ph th. : After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury	of 28c. Inju	iry at	28d. Describe	how injury	occurred	
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation				Yes 2 1				
N.	after death Director:	Ħ	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)	At home, farm, s pecify)	treet, factory, office			(Street and own, State)	Number or Hu	ral Route Number,
	To the Hospital or / within 24 hours after To the Funeral Direct completely filled in b		Vo. vi. vi.			AL		d -1 ad du- A M			stated
	To the Hospital within 24 hours a To the Funerat Completely filled	edical	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my er: On the basis of exa and manner stated.	mination and/or i	in occurred at the t nvestigation, in my	opinion, deal	d place, and due to the th occurred at the time	, date and	place, and due	to the cause(s)
	thin 2 the omple	Mec	29b. Signature a d title of certifier)		29c. Licen	ise number		29d. Date	signed (Month	n, Day, Year)
	F ≩ F 8		Mullilles	Mun		73	156	3	AUSI	UST T	7,2004
	di		30. Name and address of person who cou	mpleted cause of death	(Item 23a) (Type	, Print)					
	10		CHAMES M. BEA	INER MO	201 Ru	SSELL AV	ENUG	GATHERS	BURG	MD	20877
20	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's S		1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:34 09 2004 August Thelma /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 7762 West Drive 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 02 1 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 XF 340-18-2662 Yrs. 1921 NE 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County **ehow** item 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examiner Funkt by natified at Glen Burnie 1 ☐ Yes 2 X No Anne Arundel Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with USA 21060 811 North Shore Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 🗓 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene.
7 ie marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Glass Packer 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 ie marked any injury or other traumatic ev 0ueen Gritton Nellie Frederick Lange 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7762 West Drive, Glen Burnie, MD 21060 (daughter) Carolyn L. Boehmer Date 13 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Metro Crematory Inc. 2004 * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 22. Name and Address of Facility 21. Signature of Funeral Service Lickns once 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate
Interval Between
Onset and Death
MONTHS Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o. injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran-Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 20 No 2X No 1 Yes : After this certifical funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) are and address of person who completed cause of death (Item 23a) (Type, Print) 5 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 2 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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completely

State

Medical

Registrar

29a. Certifier

29b. Signa

d title of ertifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 🗌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number OCME: August 10, 2004

111 Penn Street, Baltimore, Maryland 21201

Natalie Ramos -Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Amend item/19	e Type or Pri 1,20b-c per State of M				VII Copie: Viental Hy	00	egible.	05011
		Registrar 1. Decedent's Name (First, Middle,	f 4)		ertificate of	Death	La Data et D	Reg. No.		20014
Physicia	an	,	,		_		2. Date of D Month	Day	Year	3. Time of Death
/Medic			Martins M					t 10,	2004	8:05 PM M
Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of Death	1	4c. Co	unty of Deat	1
		Montgomery Hos 5. Social Security Number		House je (In yrs. last birthda		Rockville If Under 24 Hrs.	0.0000	41	Montg	
Funeral			S.Sex 7.Ãg 1 □ M 2 🖾 F	Vre	Months Davs		(Month, D	ay, Year)		nplace (State or Foreign untry)
Director		577-72-2295 Usual Residence of Decedent		56			October	5, 1947	7	Portugal
land ow		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
Many	to	Maryland Mont	gomery			Bethesda				1 ☐ Yes 2 🔀 No
with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number	gomery		10f. Zip Code	bechesua		10g. Citizer	of What Co	untry?
3a o		4502 Azz	mere Stree	+		20814			Portu	~ a 1
death ms 2	Funerai	11. Marital Status	12. Was Decedent		Was Decedent of If Yes, specify Cut		pecify Yes or N	0- 14.	Race - Amer	
rs after deal		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 🛣	No			o Rican, etc.)		Black, White	, etc.
al', c	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Sp	ecify:	White
filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itams 23a or 28a-f show int, the Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest		16a. De	cedent's Usual Occu	pation	t in a	16b. Kind	of Business/I	
thin 7	pie	Elementary/Secondary (0-12)	College (1-4or	5+)	ive kind of work done a. DO NOT use retire	ed)	Killy			
od wi	Son	8			Cat	erer		1	Hospit	ality
at Hy at Hy at oth	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	ne (First, Middle	e, Maiden Su	mame)	
should be ind Mental marked o	<u>1</u> 0	Antoni	lo Marques (Geraldo			Ana de	Jesus	Marti	ns
2 sho and ls my		19a. Informant's Name/Relationshi Cecilia Marie M	o (Type, Print)	19b. Ma	ailing Address (Stree	t and Number or Ru	ral Route Numi	er, City or To	own, State, Z.	ip Code)
and sealth n 27		Marques dos Ramo			Avamere	Street Be		Mary1	and 20	814
of High		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	I □Damoval from State	20b. Place of Dis	sposition (Name of crematory or other pla	ace)	Date		ion - City or 1	own, State
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyglene. Important: If Itam 27 Is marked othar than "natural', any injury or othar traumatic evant, I're Modical Exe once.		`4 □Donation 5 □ Other (Spe		S. Ramao	Town Ceme	tery 19,	2004	s.	Romao Ramao	Portugal
permit. Departr Imports any inji		21. Signature of Fineral Service Li	censee /		22. Name and Addr.	ess of Facility Roh	ert A.	Pumphi	rey Fu	neral Home/
9 E E G	(C - (A	Clean)	calast	M00335	Bethesda-C Bethesda,	nevy Chas Maryland	20814-3	3501	Wisco	nsin Avenue
	6	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused by one cause on each li	the death. Do not one.	enter the mode of dy	ing, such as cardiac	or respiratory	arrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Primars	_Peritone	al Carcin	onatogia				Onset and Death
/Medical		resulting in death)		a consequence of):	car carcin	Onacosis		-		Years
Examiner		Sequentially list conditions	b							
p =	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a consequence of):						
nd	am	that initiated events	c							
The faw requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
icate b physic s the b	licai		d							
ing p	Physician/Medica	IF FEMALE:								
eath cert attending for use	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc	:y		23d.	Date of deliver. Month	
the a	Sici	1 ☐ Yes 2 💢 No	4☐Pregnant at 9☐Unknown	t time of death	5 Other (specify)			į	MORE	Day Year
at the	Phy	9 Unknown								
res that igned to be det	by	Part II. Dther significant condition	s contributing to death b	ut not resulting in the	e underlying cause gr	ven in Part I.				the cause of death?
w requir been si should	ted						1	Yes 2XIN	lo 3 Pro	bably 4 Unknown
e faw i has b	Completed						24a. Was	psv	4b. Were aut	opsy findings available ompletion of cause of
	Con						perf	ormed? 2X No	death? 1 ☐ Yes	2 □ No
sician: T certificat rector, pa	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	one)		
Physic this ce al dire	2	1 ☐ Yes 2 🔀 No	Hospital: 1 🗌 Inpatie	ent 2 ER/Outpat	ient 3 DOA	her: 4 🗌 Nursing H	ome 5 Res	idence 6 🛣	Other (Speci	hospice
ng P		27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time		ry at	28d. Describe	how injury oc	curred	
sndi sath. or: A he fu	Certification;	2 Accident investiga			M 1	Yes 2 □ No				
r Att	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	Ad 1 280. Place of Inf	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Street and Ni wn, State)	umber or Rur	al Route Number,
rs aff	Cer									
To tha Hospital or Attanding Physician: within 24 hours after death. To tha Funaral Diractor: After this certific completely filled in by the funeral director.	edicai	29a. Certifier 1X Certifying (Check only 2 ☐ Medical Ex	Physician: To the best caminer: On the basis o	of my knowledge, de	eath occurred at the ti	me, date and place,	and due to the	cause(s) and	manner as	stated.
tha h tha F tha F		one)	and manner st	ated.						
To To Corr	Σ	29b. Signature and title of certifier	2		29c. Licen:	se number		29d. Date si	gned <i>(Mo</i> nth,	Day, Year)
σ_{i}		I Chile y	you	want to		MD42452		Aus	gust 1	1, 2004
12										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, M.D. 18111 Prince Philip Drive #327 Olney, Maryland 20832									
Sta Registr		31. Date filed (Month, Day, Year) AUG 1 2 2004	82. Registr	ar's Signatur	Spale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 10, 2004 /Medical 4a. Facility Name (If not institution, give street 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Vr Ab Burns 7. Age (In yrs. If Under 24 Hrs. 5. Social Security Number 219-322986 last birthday) If Under 1 Year 8. Date of Birth Month, Day, APK-3 6. Sex **Funeral** Birthplace (State or Foreign
Country) 1**™**M 2□F Months Days Hours Min Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? or Items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: 1952-58 3 Widowed 4 Divorced "natural" Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne eny injury or other treumatic event, the Medic 2006. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ACKSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RNIEMDZIOGI 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 4 Donation ral Service Licensi 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part 1. Enter the disease, of complications in the easted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of) **Examiner** cell Sm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Toos 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an 25 No of Vital 1 Yes Hospital or Attending Physicien: in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Tes ₽-No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? Dale of Injury (Month, Day Year) 28b. Time of Injury 27. Manger of Death 28d. Describe how injury occurred 1 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 2804 5 who completed cause of death (Item 23a) (Type, Print) mD OFI V 13 V

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 2 2004

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 MARY KECK MALON August 10:30P /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Pickersgill Towson Baltimore Months Deys Hours Min. April 5, 19 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. lest birthday) **Funeral** Months 1 M 2/XF 82 Yrs. 184-12-1144 Pennsylvania Director Usuel Residence of Decedent filed within 72 hours efter daath with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mantal Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Maryland Baltimore Timonium 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21093 240 Chantry Road USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (A)No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: White Specify: Be Completed by 3℃Widowed 4 □ Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Baltimore County 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) Philip Keck Sr Katharine Hayes 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathalee M O'Conor DTR 628 Chestnut Avenue Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Buriel 2 Cremation 3 Removal from State Dulaney Valley Memorial Gardens 8/11/04 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility Mitchell-Wiedefeld Funeral Home Inc. gnature of Funeral Swice Licenses 6500 York Road Baltimore, Maryland 21212 23a. Pert1. Enter the Usees of complicity his that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only only cause on each line. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Ancreat ic CONCER months Examiner Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate ba axecuted be datached for use es the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): end Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy mellitus 1 Yes 250No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred Injury 1 Naturel 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the tun. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of certifier 025205 ino 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6701 N. Charles St. Balts Md 2120% Rilay GAMI

Registrar

State

31. Date filed (Month, Day, Year) AUG 1 2 2004 /32. Registrer's Signature

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Unpend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item # 23a, 27, 28a-f, per ME, G835, 979704 IT
State of Manyland / Department of Health and Mental Hygiene

	1 - State Registrar		rtificate of Death	Reg.	2004 25347	
ian	1. Decedent's Name (First, Middle, Last) Clarence Myerly			2. Date of Death AUGUST	3. Time of Death 2:55 P	
cal ner		oer) . Age (In yrs. last birthday)	4b. City, Town, or Location of Death BALTIMORE CITY If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yes	4c. County of Death N/A 9. Birthplace (State or Fore	aign
	175-52-2318	37 Yrs.	Months Days Hours Min.	September 4	, 1966 Maryland	
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation	-	10d. Inside City Lim	iits
tor	Maryland N/A	Balt	imore		1 X □Yes 2□1	No
i Direc	10e. Street and Number 3019 Chestnut Avenue		10f. Zip Code 21211	10g. (Citizen of What Country?	
nera		ent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian, Black, White, etc.	
Be Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Date	XXνο	1 ☐ Yes 2 No Specify:	Thous, ste.,	Specify: White	
oleted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b.	Kind of Business/Industry	
Com	Elementary/Secondary (0-12) College (1-4	Labore	r	Co	nstruction/Roofing	
Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid		
To	Clarence Edward Myerly 19a. Informant's Name/Relationship (Type, Print)	19h Maili	Betty J	. Kirkpatrick		
	Richard Kirkpatrick/Brother		Imperial Drive Laure	·	,	
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify)		osition (Name of matory or other place) rt of Jesus 8/13		Location - City or Town, State	
	21. Signature of Funeral Service Licensee Christi	na L. Hilton 2	2. Name and Address of Facility eonard J. Ruck. Inc.			
	23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on ear	used the death. Do not ent	305 Harford Road Bal er the mode of dying, such as cardiac		Approximate Interval Between	
	According Committees	otic Intoxica	ation		Onset and Death	
ı	resulting in death) Due to (o	r as a consequence of):				
Je J	Sequentially list conditions, if any, leading to immediate b. Due to (o:	r as a consequence of):				
amin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events c.			·		
edical Examiner	resulting in death) Last Due to (o	r as a consequence of):				
	IF FEMALE:					
by Physician/N	23b. Was decedent pregnant 1 Live bird	nt at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
Phys	9 L Unknown		ndarhing equen given in Part I	23e Did tobacc	o use contribute to the cause of death?	
d by	Part II. Other significant conditions contributing to dea	an bat not resulting in the a	noenying cause given in Fait i.		2 No 3 Probably 4 Unknow	
Completed				24a. Was an	24b. Were autopsy findings availab	ble
omo				performed?		Л
Be	25. Was case referred to medical examiner?			th (Check only one)		
. To	1 X Yes 2 No Hospital: 1 ☐ Ing 27. Manner of Death 28a. Date of	Injury 28b Time o		ome 5 Residence 28d. Describe how in		_
atlon	1 Natural 5 Pending 2 Accident investigation	Found	Work? M 1 ☐ Yes 2 X No	Unknown		
Medical Certification;	3 Suicide 4 Homicide 3 Could not be determined 4 Homicide 4 Tot	of Injury - At home, farm, str g, etc. (Specify)	eet, factory, office	3019 Ches	and Number or Rural Route Number, step	
dical C	29a, Certifier 1 Certifying Physician: To the b	pest of my knowledge, deat sis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occu	and due to the cause rred at the time, date a	(s) and manner as stated. Indicate the cause (s)	
Mec	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)	
	I Worker They	ull w	OCME	A	AUGUST 8, 2004	
	30. Name and address of person who completed cause		111 Penn Street	. Baltimor	re, Maryland 21201	

State Registrar

DHMH 17 Rev 1/2001

AUG 1 2 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1

				For State	State of Mar			Health and M	1ental Hyg	jiene	05010
				Registrar 1. Decedent's Name (First, Middle, Last)		Cei	tificate of	Death	2. Date of Dea	leg. No. UU4	3. Time of Death
		Physici		Robert B. Moore					AMONTH AUGUST	Day Year	5,25 PM
	E	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Town,	or Location of Death	1000 401	4c. County of Dea	ath
		Exami		Joseph Richey Ho	spice		Baltim	nore		N/A	
		Funeral		5. Social Security Number 6. Sex 12 N	7. Age ((In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign ountry)
		Director		237-46-4849 TSUN Usual Residence of Decedent	207	69 Yrs.			Jan 29	,1935	NC
		land ow		10a. State 10b. County	1	IOc. City, Town or Lo	cation				10d. Inside City Limits
		Many Pert sh	tor	MD N/A		Balti	more				1 XYes 2 ☐ No
		or 28	Jirec	10e_Street and Number			10f. Zip Code	21223	1	Og. Citizen of What Countries St	ountry?
		23a	rai	701 Arlington A							
		items items	Funeral Director	11. Marital Status 1 Never Married 2 Married	Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No	er in U.S. 13.	**	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ite, etc.
	5-0036	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1⊡Yes 2A⊡No	Specify:		Specify: 1	Black
	5-0	72 ho	Completed	15. Decedent's Educat (Specify only highest grade of	tion ompleted)	16a. Dece	dent's Usual Occu kind of work done	ipation a during most of work ed)	ing	16b. Kind of Business	s/Industry
	2121	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		oo not use retire aborer	ed)	(Construct	ion Compan
X	2	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or items 23a or 28e-f show with the Medical Examiner must be notified at		12 17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
1/	an	ld be ental ked o	To Be	Robert Moore				Pear	1 Willi	lams	
	Maryland	shou s mar	-	19a. Informant's Name/Relationship (Type			-			r, City or Town, State,	
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic svent, the Medical Examinet must be notified at ODCe.		Bennie Johnson/S	on	2304	N. Ais	squith S	t. Balt	imore,MD	
,	Baltimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	noval from State	20b. Place of Dispo cemetery, crea		200)	# B	20c. Location - City o	
. 15	ţ	t. Partmen rtmen rtent: njury		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	A.	Western		ery ;		Baltimore	
200	Bal	Depa Impo any ii		1 Cohand	Henry		Twin L. O. Box	11651 B	ms Fune altimor	eral Serv ce, MD. 2	ice, P.A. 1229
S				23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the	ne death. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition resulting in death)	Asper		inus i	infection	1		Weeks
50		/Medical Examiner		Totaling in county	7	cedsequence of):	ression				
7			ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	0000	1233101	^			
2/9/		cuted nd ransit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Ren	al tru	splant				1
	, 0,	e exe vian ar urial-t		resulting in death) Last	Due to (or as a	consequence of):	1				
3	68760,	fficate be executed g physician and as the burlat-transit	edicai	d	Ker	nal tai	inre				
3 17	-	= 00 00		IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of					23d. Date of de	livery
3	Box	death e atten ed for u	Physician/M	in the past 12 months?	1 Live birth 2 4 Pregnant at tir]Ectopic pregnand] Other <i>(specify)</i> _	cy 		Month	Day Year
M	P.0	at the by the	hys	9 🗆 Unknown	9 Unknown						
	_	w requires that the death cen been signed by the attendin should be detached for use	by	Part II. Other significant conditions contrib	buting to death but	not resulting in the u	nderlying cause gi	iven in Part I.		bacco use contribute t es 2□No 3□P	o the cause of death?
D	Records,	law req as been 2 shou	Completed						24a. Was a		utopsy findings available
OURE		The la	шо					-	autops perform	med? prior to death? 2☑No 1 ☐ Ye	completion of cause of
0	Vital	ian: intifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat			-14
~	of V	Physician: The lav this certificate has ral director, page 2	To	1 ☐ Yes 2, ☐ No Hos	spital: 1 Inpatient		IL 3 DOX		me 5 Reside		ocity ospice
+		ling P	ion:		28a. Date of Injury (Month, Day 1	Year) 28b. Time o	Wo	ury at ork?]Yes 2∐No	28d. Describe ho	ow injury occurred	,
es.	Division	death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injun	y - At home, farm, sti (Specify)				treet and Number or F	ural Route Number,
obert	D	safter safter bil Dire	Certification:	4 Homicide	building, etc.	(Specify)			City or Town	n, State)	
E		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) Certifying Physic 2 Medical Examina	ian: To the best of r: On the basis of e and manner state	xamination and/or in	n occurred at the t vestigation, in my	time, date and place, opinion, death occur	and due to the c red at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
		To the Within To the	Me	29b. Signature and title of certifier				nse number	2	9d. Date signed (Mon	th, Day, Year)
				> Z= Bo MA			D	24170		August 10	2,2004
	1)			30. Name and address of person who com	11 3	022.	Print)	St Bal	ti more	MD 212	201
		Sta		31. Date filed (Month, Day, Year)	32. Registrar		9 100	w//	7		

				State of Ma							-		gible.	
			1 - State Registrar				rtificate				_	Reg. No.	104	25349
	Physici	an	1. Decedent's Name (First, Middle, Last)	/							2. Date of De Month	Day	Year	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give:	street and number		, Center	4h City T	Town or	Location of	of Death	August		2004 unty of Death	03:30 AM
1	Examir	ier	11	aryland	Med	tical	~	E .	200			40.00	any or Death	N/A
	Funeral		5. Social Security Number 6. Sex			ast birthday)	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Month Da AUG. 14	th 17. 17981) 1	9. Birth	olace (State or Foreign
	Director		176-14-0473		92	Yrs.					AUG.14	,1911		GERMANY
	nyland how		10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Limits
	Ba-f g	ecto		WARD		COLU								1 ☐ Yes 2 🕅 No
	3a or 3	Funeral Director	10e. Street and Number 5400 VANTAGE POIN	T ROAD AT	т. 6	01	10f. Zip (21044	ļ.		10g. Citizer	of What Cou	USA
	ems 2	nera		12. Was Decedent E Armed Forces?			Was Decede				ecify Yes or No Rican, etc.)	- 14.	Race - Ameri Black, White,	can Indian,
36	s after	by Fu	1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	1 ☐ Yes 2 🛣 N If Yes, Give	lo	1	1 ☐ Yes 2		Specify:	, 1 40110	riidari, Gto.)		ecify:	WHITE
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show fra Medical Exercit or must be retilled at	ted t	15. Decedent's Edu			16a. Dece	dent's Usual	Occupa	ation			16b. Kind	of Business/In	dustry
215	d within 72 ho giene. Ir than "netu Ir e Medical	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work			t of work	ing	CNCT	NECDIN	C
d 21	illed w Hygier other th		17. Father's Name (First, Middle, Last)	T		CIVI	L ENG	INEE		r's Nami	e (First, Middle		NEERIN	G
Maryland	e d la la	To Be	JOSEPH		0EST	ΓREICH	ER		PAL		, , , , , , , , , , , , , , , , , , ,	S.		FRANK
lary	2 2 20 20		19a. Informant's Name/Relationship (Ty	-			-				al Route Numb			Code)
	s 1 and 2 f Heelth Item 27 I		SUZANNE ROSENBER	G / DAUGH							COLUMB		0 21045 ion - City or To	own State
mor	of of		1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ace of Dispo emetery, cren LUMBIA				/11	/2004		.UMBIA,	
Baltimore,	permit. Pag Department Importent: I any Injury o		21. Signature of Funeral Service License	90	1 002						_ LEVIN:			
8	89 E 29		1 Tober W										ILLE,	MD 21208
	2		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	e cause on each lin	the death e.	. Do not ent	er the mode	of dying	g, such as	cardiac i	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	_	ience of):								
Н	Examiner	U	Sequentially list conditions,											
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter underlying that initiated events	Due to (or as a	i consequ	ience of):								
oʻ	te be executed ysician and ie burial-transit		that initiated events resulting in death) Last	Due to (or as a	consequ	ience of):								
8760	9 % 9	licai		l										
89 x	death certificate be attending physic	/Med	IF FEMALE:	3c. If yes, outcome	of pregnar	ncy						234	. Date of delive	201
. Box	0 0 0	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pre Other (spe					200	Month	Day Year
P.0	that the de led by the a detached f	Phys	9 Unknown			data a ta aba			. i. B. at		00 - Did 4			
ds,	8 5 8	ρ	Part II. Other significant conditions con	tributing to death bu	t not resu	itting in the ur	iderlying cai	use give	in in Part I.				io 3 ☐ Prot	he cause of death? pably 4 Junknown
Records,	law requir as been si 2 should l	ompieted									24a. Was		4b. Were auto	psy findings available
- Re		Com		-								rmed? 2 ☐ No	death?	mpletion of cause of 2□ No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				Othe			Check only o			3a - 8
of		n: To	27. Manner of Death	28a. Date of Injur	y	ER/Outpatien 28b. Time of		c. Injury	at		me 5 Resident			iy)
sion	토 등 등 글	atlo	1 Natural 5 Pending investigation	(Month, Day	rear)	Injury	М	Work 1 🗆 Y	? /es 2 □!	No				
Division	or Attendatter deatt Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju building, etc			eet, factory,	office			28f. Location (3 City or Tox		umber or Rura	al Route Number,
_	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Cartifying Phys	ician: To the best o	f my knov	vledge, death	occurred at	t the tim	e, date and	d place,	and due to the	cause(s) and	d manner as s	tated.
	the Ho hin 24 h the Fu npletely	edical	one)	and manner sta	examinati	ion and/or inv	estigation, i	n my op	oinion, deat	h occurr	ed at the time,	date and pla	ice, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Pu -1	M	17	29c.	License	number			29d. Date si	gned (Month,	Day, Year) ugust 09,
	an		30. Name and address of person who co	mpleted cause of de	ath (Item	23a) (Type.	Print)	JT	17			0/1	7	2004
	,1		MeghanLyn	ch 2	2.	S. G	ree	ne	- 5	it.	. Ba	ltim	ore, i	MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	_	ure							•	
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EMELINE PETERS 04 - 5174Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. dap Tem#18, State of Maryland / Department of Health and Mental Hygiene
1- Registrar Registrar Registrar Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Peters **AUGUST** Emeline 2004 8:00p /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SINAI HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **X**M 2□ F Yrs. 76 215-68-1261 30 Jamaica Director Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County itam 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event. If a Modical Examinar must be notified at 1 X Yes 2 □ No Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 5612 Park Heights Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 Never Married Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Black Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nurses Aide 6th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe Iris McCloud Iris McLeod James Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health 5612 Park Heights Ave, Baltimore, Md 21215 Cecil Peters-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Pages ' 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Jamaica permit. Page Department c Important: If any injury or once. ō West Indies 4 ☐ Donation 5 ☐ Other (Specify) 8/17/04 Denbigh Maypen 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F/H West 21215 Baltimore, Md 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart bailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mutastoutic cargaoma 1445 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit Due to (or as a consequence of): physicien Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year õ in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 3 ☐ Probably 4 ☐ Unknown nertension 1 ☐ Yes 2 ☐ No Completed obstructive 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No P4/mores 24a. Was an autopsy performe 1 Yes 2 page 2 certificate 2 No Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home Hospital: 1X Yes 1XXnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 2 🗌 No of this filled in by the funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t Certification: 1 Natural
2 Accident Injury or Attending 5 Pending investigation 1 Yes 2 No death. Diractor: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide determined after 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME **AUGUST** 10, 2004 address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 30. Name BILLEC

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 2 2004

32. Registrar's Signature

			For State Registrar	State of	Marylan		artmen			and Me		giene	no.	25351
		П	Decedent's Name (First, Middle,	Last)						1	2. Date of De.	ath		3. Time of Death
	Physicia /Medic		Julia	Alice		I	Puller	n			Month August	7, Day	2004 Year	5:00 A M
	Examin		4a. Facility Name (If not institution,	give street and num	ber)	-	4b. City,	Town, or	Location of	of Death			County of Death	
			Larkin Chase		Y A //	In an in instruction of the call	Bo If Under	owie	If Under:	24 Hrs To	B. Date of Birt		ince Ge	
	Funeral Director		5. Social Security Number 246-10-4523	3. Sex 1 ☐ M 2/CX F	7. Age (In yrs 94	Yrs.	Months	Days	Hours	Min.	Month, Da	y, Year)	Cou	place (State or Foreign intry) n Carolina
			Usual Residence of Decedent									,		
	rrylan show	_	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits 1 Yes 2 □ No
	Sa-fs	cto	NC New Har	nover	Wi	lmingt		0.1				10- 011	zen of What Cou	
	with the	E P	10e. Street and Number 803 S. 13th Str	.			10f. Zip	3401				U.S		intry?
	ns 23	Funeral Director	11. Marital Status	12. Was Dece		.S. 13. 1			spanic Orig	gin? (Spec	ify Yes or No ican, etc.)		14. Race - Amer	
0	or Iter	필	1 ☐ Never Married 2 ☐ Marrie	Armed For d 1 ☐ Yes	2 🕅 No 🔠						ican, etc.)		Black, White	
0000	irel', c	d by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 Yes		Specify:				Specify: Blac	ck
<u> </u>	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene than "neturel", or Items 23e or 28e-f show after than "neturel", or Items 23e or 28e-f show ant, the Marifeal Exameter instituted at the statement of	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	al Occupa rk done d	ition <i>Juring m</i> osi I	t of working	7	16b. Ki	nd of Business/I	ndustry
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	e filed I Hyg other	Be C	17. Father's Name (First, Middle, L	ast)		1			18. Mothe	er's Name (First, Middle,	Maiden	Sumame)	
<u>a</u>	should be nd Mental marked c	To E	Roberts Wertz						Rel	becca	Mille	r		
2	Cl 42 20 20		19a. Informant's Name/Relationshi				_						r Town, State, Zi	p Code)
≥ oĵ	1 and lealth om 27 ther tr		Allen Johnson 20a. Method of Disposition	(Son)	20b. F	8804			Dr.,	_Lanh Da	am, MD		06 cation - City or T	own State
	permit. Pages Department of the Importent: if ite any injury or of once.		1 X Burial 2 ☐ Cremation		State	emetery, crei	matory or o	ther place	1					
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	rted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Delli	onl	ia							
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ğ	e as the		IF FEMALE:	20. 14										
X Q Q	death cone attended for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?		rth 2 ∏ Feta ant at time of d	Ideath 3	☐Ectopic pr ☐ Other (sp					1	23d. Date of deliv Month	very Day Year
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	icien: The lav certificate has rector, page 2	Con									1 Yes	rmed? 2 A No	death? 1 ☐ Yes	2□ No
Vital	Physicien: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o			
0	dis	. To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date o		ER/Outpaties 28b. Time o		28c. Injury Work	4 4 4		e 5 ∐ Resid 3d. Describe I		Other (Special occurred)	ify)
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	o the o the omple	Med	29b. Signature and title of certifier	and mani	101 3(2100.		290	c. License	number	(~	29d. Dat	e signed (Month	Day, Year)
	/							DC	271)28	5	Œ	1-179.	-04
	h		36. Name and address of person v	no completed caus	e of death (Iter	m 23a) (Type,	Print)	C++	- 00	1 AN	NAG	115	mD	21401
			31. Date filed (Month, Day, Year)	11111 C	egistrar's Signa	OTLY ature	TIVE	>1t	10	1/1/			, , , , , ,	01-101
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	Physic	ian	Decedent's Name (First, Middle, La	st)				2	. Date of Dea	NOW TO SERVICE	3. Time	of Death
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	th the M or 28a-f	Director	10e. Street and Number			10f. Zip Code				Og. Citizen of	What Country?	
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Division	ne Hospitel or Attendi 124 hours after death 18 Funerel Director: A sletely filled in by the fo	Certification;	4 Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, streen ecify)	et, factory, office		28f.	Location (Stre City or Town,	et and Numbe State)	er or Rural Route Nur	nber,
	G ⊃ k =		29a. Certifier 1 Certifying Phys	sicien: To the best of my	knowledge, death	occurred at the time,	date and	place, and	due to the car	use(s) and mar	ner as stated	
		ledical	one)	ner: On the basis of examand manner stated.	nination and/or inve	stigation, in my opin	ion, death	n occurred a	t the time, dat	te and place, a	nd due to the cause(s)
	To Too	Σ	29b. Signature and title of certifier	(P) 0.		29c. License n		_		_	(Month, Day, Year)	
			Mulyma	re Jull	J		C.M.E	i.	J	uly 04,	, 2004	
		1	30. Name and address of person who co									
	Stat	e S	31. Date filed (Month, Day, Year)	32. Registrar's Si	innature	Penn Stre	et, I	Baltin	ore, M	aryland	1 21201	
iç i	Registra		AUG 112	2004	1 1 1	onle						
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	0,		1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h		ne of Death
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>	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death	17 1001001	4c. County		
			Union Memorial	Hospital		Baltin	nore		N/A	1	
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36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	I□Yes ሺ No	Specify:			Barbad	
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5	ages int of t: If i		1X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify		cemetery, cren t . Zion	natory or other place)	8-9		_		
Baltimore,	permit. Pa Departmen Important any injury		21. Signature of Funeral Service Licens							cowne, M	u.
Ba	permit. Pages of Popartment of Plengartment. If ite any injury or of other		Lloyd M. Es		E	Name and Address of Step Bro	thers :	Funeral	Ser, F	A	177
	-		23a. Part1. Enter the d.s ase, r com	ications that caused the dec		300 Euta				Id. 212	
			shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	zui. Do not ont	or the mode of dying,	such as cardiac	or respiratory arre	331,	Interva	Between and Death
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/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	1				h (Check only on			
Ę	Physi this o	ို	12 163 22 100	Hospital: 1 Anpatient 2	-			me 5 Reside	nce 6 Othe	er (Specify)	
L	ding P. h. After t funera	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		28d. Describe ho	w injury occurre	ed	
Division	eath.	catl	2 Accident investigation			M 1 Yes	s 2 No				
Ξ	r Att	Ē	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location (Sti City or Town		er or Rural Route	Number,
	itel c										
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	To the Hospitel or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	led	0116)	and manner stated.							
	To To	Σ	29b. Signature and title of certifier	4.45		29c. License n				(Month, Day, Ye	
•		55	Sompt	5, MD				6 A			
	to		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, I	Print) SMAI	LI GIL	JPTA, N	D		T
_	Ψ		UNION MEMORIA			JIE UN	VERST	Y PARK	KWAY,	BALTI	MORE, M
	Sta Registra		31. Date filed (Month, Day, Year) AUG 1 2 20	32. Registrar's Sign	ature &	sporks					

			ricase	State of Manuage / De				-	
			1 - For State Registrar	State of Maryland / De	epartment of Certificate of			0001	00001
			Registrar 1. Decedent's Name (First, Middle, Last		vertificate of	Dealii	2. Date of Dea	eg. No.	3. Time of Death
	Physici		Patrick Charles R				August	Day Yea	ar . france on
	/Medio Examin		4a. Fecility Name (If not institution, give		4b. City, Town,	or Location of Death	Hactors	4c. County of De	
			Union Memorial Ho	spital	В	altimore			N/A
	Funeral		5. Social Security Number 6. Se	384 005	Months Days		8. Dete of Birth (Month, Day		Birthplace (State or Foreign Country)
'n,	Director		261-68-0404 Usuel Residence of Decedent	57 Yr	s.		Sep. 1,	1946 M	aryĺand
	/land		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Man 1-f sh	tor	MD Balti	more	Balt	imore			1 ☐ Yes 2X No
	or 28;	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	Country?
	23a		2107 North Rollin	g Road		21244		United St	ates
	tems	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of If Yes, specify Cut 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rece - Ar Black, W	merican Indian, hite, etc.
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes Ž X No	Specify:		Specify:	White
9	be filed within 72 hours after deeth with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show sysht, the Madical Exeminal must be notified at	ted	15. Decedent's Edu	cation 16a. D	ecedent's Usual Occu	pation		16b. Kind of Busine	ss/Industry
215	hin 72	plet	(Specify only highest grad Elementary/Secondary (0-12)	e completed) (0	Give kind of work done fe. DO NOT use retire	during most of work	ring	TOD: TURE OF BUSINES	33 madatry
2	ad wit	Completed		1	Insurance	Broker		Self Em	ployed
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
$\frac{2}{3}$	i Men i Men narke	To	Robert A. Russell				t A. Mul		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any figury or other traumatic svant, the Middial Exeminer must be notified at ODCe.		19a. Informant's Name/Relationship (T) Marcia Russell W		lailing Address (Stree				
ē,	Heal Heal tem 2		20a. Method of Disposition	20b. Place of D	07 N. Roll isposition (Name of			20c. Location - City	
Baltimore,	Pages ent of st: If I		1 XBurial 2 ☐ Cremation 3 ☐ F		rematory or other pla Idge al Park	4			
<u>=</u>	partm partm sorts rinju		21. Signature of Funeral Service Licens	1\ PIEMOTI		ess of FacilityAmb	4-2004 rose Fun	Elkridge	, MD Tnc
m			athline NK	WILL W01381	1328 Sulph				
			23a. Pert1. Enter the disease, or compi shock, or heart failure. List only o	ications that caused the death. Do not not cause on each line.	enter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ACOUTE MYOCA	RAIAL IN	SFARREIRE	7		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of)					-
и		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of)	14 757A3	32436			Shocks
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o,	be executed sicien and burial-transit		resulting in death) Last	Due to (or as a consequence of)					
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x 68	leath certificate attending phy I for use as the	Physician/Medi	IF FEMALE:						
Вох	attend attend for us	lan/	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnand	су		23d. Date of d Month	lelivery Day Year
o.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of death 9☐ Unknown	5 ☐ Other (specify) _				,
Division of Vital Records, P.O.	that ned by deta	by Pt	Part II. Dther significant conditions con	ntributing to death but not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did lot	pacco use contribute	Io the cause of death?
rds	w requires that been signed be should be det	q pa					1 □ Ye	s 2 No 3	Probably 4 Dnknown
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/ita	ysician: The l is certificate ha director, page	Be	25. Was case referred to medical examiner?			26. Place of Deat			
of	Physi this c	٦.	1 ☐ Yes 25€No 27. Manner of Death	lospital: 1 Impatient 2 ☐ ER/Outpi	Illetti 3 DOA			nce 6 Other (Sp	pecify)
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S	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, larm			28l. Location (Sti	reet and Number or i	Rural Route Number.
	s afte	Certification:	4 Homicide	building, etc. (Specify)			City or Town	, State)	
	To the Hospitel or Attending Physical within 24 hours alter death. To the Funerel Director: After this completely filled in by the funeral di		(Check only 2 Medical Exami	sician: To the best of my knowledge, oner: On the basis of examination and/o	eath occurred at the to	ime, date and place,	and due to the ca	tuse(s) and manner	as stated.
	the hin 24 the F	Medicai	D MA	and manner stated.					
•	T wil		29b. Signature and title of certific)	29c. Licen:	se number	29	9d. Date signed (Mor	ntn, Day, Year)
	di		30. Name and address of person who co	moleted cause of death /ltom 22c) /T-			14	rages 1	6,2564
	10		MARCINA A		De, Print)	الا لنة الك	end Am	e # 302	BALTO ZIZZ
悉	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature					
100	Registr	ar	AUG 1 2 2004	Server &	1 4				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year HELGA 10:10 A N KEYNOLD S C. **AUGUST** 2004 4b. City, Town, or Location of Death 4c. County of De 4a. Facility Name (If not institution, give street and number) HOSPITAL GLEN ARUNDEL ANNE BURNIE NORTH ARUNDEL Birtholace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Days 1 ☐ M 2 🖾 F 63 216-80-4969 JAN 5, 1941 CZECHOSLOVAKIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2♥ No Anne Arundel Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 834 Springdale Drive 21108 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐ Yes 2X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2CXNo Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerlinda Richter Alfred Hasse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 703 Caleb Lane Annapolis, MD 21401 Christine Marshall / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD 4 □Donation 5 □ Other (Specify) 2004 Lakemont 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Singleton Funeral Home PA MO1220 1 Second Ave S.W. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute respiratory distress syndrume disease or condition resulting in death) Due to (or as a consequence of shock DIIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): cditis Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Thipatient 2 ER/Outpatient 3 DOA 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tes 2 □ No 2 Accident

/Medical **Examiner** Examine burial-transit certificate be executed and the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760 this certificate has Hospital or Attending 24 hours after death. after death. Funerel

Physician

/Medical

Examiner

Director

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Completed

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Funeral

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permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treumatic event, it is Medical Energiant must be notified at once.

Physician

KEYWOLDS,

Physician/Medical þ Completed Be Certification:

completely the within To the 0

JACOBS 31. Date filed (Month, Day, Year) State

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certified

6 ☐ Could not be

determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 9, 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Glen Burnie, MD 2106 305 Hospital Dr. MD 32. Regist/ar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

CPM 04-05136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. De'Andre Serisis State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** E'ANDre Year 07, August 2004 10:19 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) DEC. 29, 1982 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 □ F 215-02-4384 Director Yrs Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director BALLIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Tyes 2 No 3 ☐ Widowed 4 ☐ Divorced BIACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ARPENTER ON Struction 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EURON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Serists-3011 THORNDAIL AUE ADT. 2 BAHO, MD. 21215 MolHer DAWN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 8-14-04 REISTERSTOWN LUKES CHURCH CEM * 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Fun Suc. PA 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility
MICHAEL Zigher
P.D. BOX 67338 BALLO, MD, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LYUVIES with Head /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9□ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? page 120 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Injury at Work? After unsetted passenger in motor vehicle accident 1 Natural 5 Pendina investigation 3:00 1 ☐ Yes 2 ☑ No August 6,2004 22 Accident within 24 hours after deat To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Jown, State) 4900 610 CK Reifer Spwn Rd, à 4 Homicide filled in I road Baltomore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medicai completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 09, 2004 Greenserg MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Gireenberg 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					•	epartment of R Certificate of		R	eg2No.) () 4	2	5357	
	Physici /Medio		1. Decedent's Name (First, Middle, Carolyn W	Lest) J. Stephen	S			2. Date of Dear Month August	10^{Day} , 200	(ear)4	3. Time of Deat 6:30 A	
ù	Examir		4a. Fecility Neme (If not institution,	give street and number)			4b. City, Town, or L	ocation of Death	4c. County of	Death		
	Funeral Director		424-07-8760		e e (In yrs. last birthi 83 Yr	Months Days	Chevy Cl If Under 24 Hrs. Hours Min.	nase 8. Date of Birth (Month, Day) Sept. 9	, Year)	ntgo Birthpla Countr Alab	ice (State or For	eign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	or Location				100	d. Inside City Lin	nite
	Manyli f sho	ō	Maryland Montg	omerv	•	evy Chase				100	1 □ Yes 2 🛚	
	28a	rect	10e. Street end Number	omer y	011	10f. Zip Code		1	0g. Citizen of Wh	at Countr	v?	
	th with	al Di	8700 Jones Mill	Road			0815		USA			
Maryland 21215-0020	I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28e-f show event, fre Medical Examener must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U,S.	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White, et	c.	
5-0	72 h	etec	15. Decedent's (Specify only highest	Education grade completed)	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	oation during most of work	ina	16b. Kind of Busi	ness/Indu	stry	
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2	Hygie Hygie ther t		17. Father's Name (First, Middle, La	est)	Ke	y Tuileir op	18. Mother's Nam					
lan	e d la be	o Be	Smith R. Olive					en E. Gr				
ary	s 1 and 2 should f Health and Mer item 27 is merke other traumatic	2	19a. Informant's Name/Relationshi		19b. N	Mailing Address (Street	and Number or Rur	al Route Number	, City or Town, St	ate, Zip C	ode)	
	- = O -		Sharon E. Robi		er 361	5 14th.Str	eet N.W.	Washing	ton DC 2	20017		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2X☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	20b. Place of D cemetery,	hisposition (Name of crematory or other pla Crematory	Inc. 8		20c. Location - Ci Baltimon	•		[
Balt	permit. Page Department of Important: If any injury or once.	ļ	21. Signature of Euneral Service Li	or or		22. Name and Addre Cremation 299 Frede	rick Road	Baltimo	re, Mary		1 21228	
	Physician /Medical Examiner	, i	23a. Part1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Ace		JOCARDIA			est,	; li	Approximate Interval Between Onset and Death	
x 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	C	Due to (or as a cor	nsequence of):	DISCASE					
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of)	Q 55	J.	1 Yes 2 No	Hospital: 1 Inpatie		atient 3LIDOA			nce 6 Other			
- L	After funer	lon	27. Manner of Death 1 Nature 5 Pending	28a. Date of Injur (Month, Day	ry Ye <i>ar)</i> 28b. Tin Inju	ıry Wo	yat k? Yes 2 □ No	28d. Describe no	w injury occurred			
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director.	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t bo	ury - At home, farm c. (Specify)	, street, factory, office		28f. Location (St. City or Town	reet and Number n, Stete)	or Rural F	Route Number,	
	n 24 hour n 24 hour ne Funera	edical (29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of teminer: On the basis of and manner sta	examination and/o	leath occurred at the tile or investigation, in my o	me, date end place, opinion, death occurr	and due to the ca red et the time, da	ause(s) end mann ate and place, and	er as stet d due to th	ed. ne cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	unsund	M		3367		AUGUST	Month, De	y, Year) 2004,	
	/ "		30. Name end eddress of person w	no completed cause of d	eath (Item 23a) (Ty			, MD:	20877	1		
	Sta Registr		31. Date filed (Montal France)	2004 32. Registra	ar's Signature	& don	41					

			Please Type or Print in B				-	_	ole.
			1 - State Registrar		tificate of			Reg. No. 0	4 25358
ı	Physici /Medic		1. Decedent's Name (First, Middle, Last) LOUISE SCOTT				2. Date of Dea Month ALGUSI	Day.	Year 8.05 M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	or Location of Death		4c. County of	of Death
			ROLLING MEADOWS ASSISTANT LIVING 5. Social Security Number 6. Sex 7. Age (In yrs. la		BALTI If Under 1 Year		0 D-1(Bin		TIMORE
L	Funeral Director		218-22-9265 Usual Residence of Decedent		Months Days	Hours Min.	8. Date of Birt (Month, Day June 7	y, Year) 1919	9. Birthplace (State or Foreign Country) VIRGINIA
	land ow			Town or Lo	cation				10d. Inside City Limits
	Man,	tor	MARYLAND BALTIMORE	BALT	IMORE				1 ☐ Yes ঽৄঢ়ৢNo
	or 28	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?
	ath w		3616 OAK AVENUE		212			U.S.A.	
	ltems	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S Amed Forces? 1 Never Married 2 Married 1 Yes 2 24No	. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc.
5-0036	n 72 hours after death with the Maryland "natural", or liems 23a or 28a-f show edical Exama memual be modilled at		Widowed 4 Divorced If Yes, Give Year or Dates:	1	1□Yes 2ŽÍNo	Specify:		Specify:	BLACK
<u>.</u>	72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occup	oation during most of worki d)	ing	16b. Kind of Bus	siness/industry
7	withi ane. Ithan	duic	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade		CRVISOR	d)		COMMIN	NICATION
פ		Be C	17. Father's Name (First, Middle, Last)	SUPE	KVISOK	18. Mother's Name	e (First, Middle,		
Maryland	should be ind Mental s marked c umatic ave	To	ROBERT HOLMES			MARIE T	UNSTALL		
a	and risma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Rura	al Route Numbe	er, City or Town, S	State, Zip Code)
a)	os 1 and 2 should b of Health and Ments I Itam 27 is marked r other traumatic a		Janet D. Alston/Granddaughter 20a. Method of Disposition 20b. Pla	3616	Oak Ave	., Baltim	ore, Ma		21207 Dity or Town, State
ב פ	ages ent of nt: If it		1 ₺ Burial 2 □ Cremation 3 □ Removal from State	metery, crem	natory or other place	ce)			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or other once.		21. Signature of une layer year licensee	22	Name and Addre	ss of Facility			E, MARYLAND
מ	20 1 20		1 Duoma	12	06 W NOR	BROWN COM TH AVENUE			HOME P.A.
			23a. Pert Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	er the mode of dyin	ng, such as cardiac c	or respiratory are	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ACUTE Due to (or as a consequence)	MYC	CARD	IAL 1	NFAF	RCTION	
	Examiner		CORONA	RY	ARTE	RY DIG	SEASE		
١	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	•			3011-0		
	e be executed /sician and e burial-transit	Examiner	that initiated events resulting in death) Last C. HTHERO Due to (or as a consequence)		EROSIS				
	le be e ysiciar e buria	2							
200	death certiticate e attending phys d for use as the	Medi	IF FEMALE:						
X P P	ath ce attend for use	ian/	23b. Was decedent pregnant in the past 12 months?	leath 3 🗌	Ectopic pregnancy	,		23d. Date Mont	of delivery th Day Year
		Physician/Medic	1 Yes 2 No 4 Pregnant at time of dea 9 Unknown 9 Unknown	itn 5[]	Other (specify)			i	,
ນັ	iaw requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not result					bacco use contrib	oute to the cause of death?
cords	requir een si		DESSENTIAL HYPERTEN			HYPERT	1 O Y	es 2□No 3	Probably 4 Unknown
	e taw has b je 2 st	ompleted	ENSIVE CARDIOVASCU				24a. Was a autops perfor	sv pri	ere autopsy findings available for to completion of cause of
	rsician: The law s certiticate has b lirector, page 2 s	e Co	DEXTENSIVE CPINAL STEMS 25. Was case referred to medical	212	3) VERIPA	ERAL VASC	1 Yes	2 № No 10	eath? ☐ Yes 2 ☐ No
	Physician: this certition ral director,	0 8	examiner?	R/Outpatient	Oth	er: 4 Nursing Hor	n <i>(Check only or</i> ne 5 □ Resid	ne) lence 6 MOther	(Specify) ASSISTED
n 01	nding Physician: th. : After this certitios s tuneral director, p	on: T		8b. Time of Injury	28c. Injun Worl	y at 2		ow injury occurred	
DIVISION	ttendi Jeath. tor: A the tu	icati	2 Accident investigation			Yes 2□No			
<u>≥</u>	or A after Direc	Certification;	4 Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ie, tarm, stre	eet, factory, office	4	City or Town		r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To tha Funaral Director: After completely tilled in by the tune.	edical C	29a. Certifier (Check only one) 1/32 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the timestigation, in my o	ne, date and place, a pinion, death occurre	and due to the c ed at the time, d	ause(s) and mani date and place, an	ner as stated. nd due to the cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier		29c. License		1 .		(Month, Day, Year)
/	, Ko		* Kanal & Dang no			18362		tugust,	11,2004
8	S W		30. Name and address of person who completed cause of death (Item 2 KOMOL K. Dang M.D. 34SS, Wilk	ens f	he Suite	308 - B	alto.	Md 21	1229.
	Sta Registr		31. Date filed (Maprh, Day 1 Year 2004) 32. Registrar's Signatu	re &	don s	,			

			1 - For State Registrer	State of	Maryland		artmen rtificat				ental Hygi	ene	Λ1.	25250
			1. Decedent's Name (First, Middle, La	ist)							2. Date of Death	1	1134	3. Time of Death
	Physici /Medio		CONRAD THOMA		FFA						August	10,	2004	11:50 A.M
	Examir		4a. Facility Name (If not institution, gi		ber)		4b. City,	Town, or	Location o	of Death			y of Death	
			Maryland Masonio						ville				timor	
	Funeral Director			Sex 7 1 ∑ M 2□F	. Age <i>(In yr</i> s. <i>Ias</i>	st birthday) Yrs.	If Under Months	Days	If Under : Hours	Min.	8. Date of Birth (Month, Day, May 27,	Year)	9. Birthp	place (State or Foreign htry)
			Usual Residence of Decedent		73					1	May 27,	1911		unk
	show		10a. State 10b. County		10c. City,	Town or Lo	cation						1	0d. Inside City Limits
	aa-f.s	cto	Maryland Baltin	nore	Coc	keysv	ille							1 ☐ Yes 2X No
	ih th	by Funeral Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of	What Cour	ntry?
	s 23e	rai	300 Internationa	1					21030				.S.A.	
	Itam Itam	Ë	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed Ford		13. \	Was Deced f Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spec n, Puerto R	cify Yes or No- lican, etc.)	14. Ra Bla	ce - Americ ack, White,	ean Indian, etc.
336	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		1□Yes 2	∑ No	Specify:			Speci	^{ty:} Whi∶	to
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f show the Medical Examinat must be motified at	Completed	15. Decedent's E	ducation		16a. Deced	ient's Usua	l Occupa	tion		1	6b. Kind of 8		
2	ithin	npie	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4	lor 5+)	life. L	kind of wor DO NOT us	e retired,	uring most	t of workin				
2	filed with Hygiene. othar ther		47 5 4 4 1 7 5 4 4 1 7	2 years	3	I	Ingine	eer				Food 1		nery
Maryland	9 - 0 S	To Be	17. Father's Name (First, Middle, Las George	y Staffa						rs Name	(First, Middle, M	aiden Suma	,	nk.
ary	2 should b and Menti is markad	-	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Address	(Street a			Route Number,	City or Town		
	C = 14 F		Diana Walsh (granddaug	ghter)	14628	3 Thoi	nto	n Mil	1 Rd.	Sparks	, Mary	land	21152
ore	o to the	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 [Removal from St		ce of Dispo netery, cren	sition (Narr	e of		Da		Oc. Location		
Ë	Pages ment of I tant: If its jury or o		*4 □ Donation 5 □ Other (Speci		Dulan	ey Val	ley Mer	n. Gr	ins.	8-13	-04	Cimoni	um, M	aryland
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice	nsee		M	Name and	Addres	s of Facility iedef	teld :	Funeral ltimore,	Home.	Inc.	
	10140		23a Part I Enterthe disease of con	Masse	lead the death	Do not ont	6500	York	Road	l Ba.	ltimore,	Mary	land	21212
			23a. Part1. Ente Pine disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on eac	h line.	DO TIQUETIL	A 7	/	, such as t	cardiac or	respiratory arres	st,		Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	a. Sun to (or	as a conseque	رف	MXX	heis	ner.	> 00	Jease-	•		years
	Examiner			Cou	Uni Va	Acel	an I	use.	ne		Sease			•
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a Conseque.	nce of).								
	acute and trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	death certificate be executed e attending physician and nd for use as the burial-transit		resulting in death) East	Due to (or	as a conseque	nce of):								
289	physi s the t	dical	•	_ d										
	ath certific titending p or use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnanc	;y					100	22d Da	ate of delive	
Вох	death a atter d for t	hysician/M	in the past 12 months?		h 2 ☐ Fetal de nt at time of deat		Ectopic pre Other (spe						onth	Day Year
P.0	that the d ed by the detached	hys	9 ☐ Unknown	9□ Unknow										
	es tha igned be de	by P	Part II. Other significant conditions	contributing to dea	th but not resulti	ing in the ur	nderlying ca	use give	n in Part I.		23e. Did toba	cco use con	tribute to th	e cause of death?
ord	w requir been si should I		HI New Schale VI	Isculen) islene	, in	occes	ml	hole	art	1 🗆 Yes	2 🗆 No	3 🗌 Prob	ably 4 Unknown
of Vital Records,	S S S	ompleted	Hypo Mysrelin	Hyp	ertesin	~, (erthi	lis			24a. Was an autopsy	24b.	Were autor	osy findings available appletion of cause of
E H		Cor	. ,		-1-0-						performe 1 □ Yes 2	ed?	death?	2 . No
VIII.	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only one)			
of	Phys r this ral di	.: To	1 Yes 2 No	1 ☐ Inp	-	VOutpatient 8b. Time of	_	c. Injury	4 9 9 Nur		e 5 🗆 Residen 3d. Describe how)
ion	Attanding I ir death. actor: After by the funer	ation	1√Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	М	Work	? es 2 □ N			migary cocci	.00	
Division	al or Attandi after death. I Diractor: A d in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of	Injury - At home	e, farm, stre	eet, factory,	office		28	Bf. Location (Stre	et and Numb	or Rura	Route Number,
Ö	talor rsafte ralDir	Cer		Duilding	, etc. (Specify)						City or Town,	State)		
	To the Hospitel or Atti within 24 hours after de To the Funeral Directi completely filled in by ti	edical	29a. Certifier (Check only one) 1 Certifying P	nysicien: To the b	is of examination	edge, death n and/or inv	occurred a restigation,	t the time in my op	e, date and nion, death	d place, an	d due to the cau	se(s) and ma	anner as sta	ated. the cause(s)
	To tha within 2 To the Complet	Med	29b. Signature and title of certifier	and manne	stated.			License				I. Date signe		11111
	- s - ŏ		P.T. telo	to w) .		7)			250	4	1/04	_,ı · ==-'/
	N		30. Name and address of person who	completed cause	of death (Item 2	3a) (Type, I	Print)	101	764				1/07	
_			ROBERT LIBER:	D, MD -	3508	BANG	257	Bal	to,	nul	2123	Y		
	Sta Registr		31. Date filed (Month, Pay Year) AUG 1 2 2004	Se Reg	istrar's Signatur	4	lon	1	1		2123			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Francis Marion Meiser Staley $11:20p^{M}$ 2004 August 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville Baltimore Broadmead If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, May 4, 1919 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1:20Pm 1 ☐ M 2 XX F 212-12-5609 85 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show ral, or items 23a or 28a-i shov Examine must be notified at Maryland Baltimore Cockeysville 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 13801 York Rd. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: Specify: white þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. art education teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any injary or other traumatic eventone. Be Francis Saumenig John B. Meiser ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 12401 Sussex Lane Bowie, MD Faith Leahey Thielke/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory Aug. 12,2004 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 4500 York Rd. Baltimore, MD 21212 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funer 6500 York Rd. Baltimor 6500 York Rd. Baltimor a shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-tran Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 Inpatient 3 DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director:

Division of Vital

3

within 2

Medical

State

Registrar

31. Date liled (Month, Day, Year) AUG 1 2 2004

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

and manner stated

32. Registrar's Signature

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year,

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland		artment of I		d Mental Hygie	2001.	25362
	Physici /Medio	cal	Decedent's Name (First, Middle, Last Margie Pauline	Scott		4h Cibi Taua	and another of D	2. Date of Death Month August 6,	Day Year 2004 4c. County of Deal	3. Time of Death 11:30P M
	Examir Funeral	ier	4a. Facility Name (If not institution, given Southern Maryland 5. Social Security Number 6. S	Hospital	st birthday)	4b. City, Town, of Clinton If Under 1 Year	If Under 24 i	Hrs. 8. Date of Birth	Prince Ge	eorge 's
	Director		Usual Residence of Decedent	□ M 2 🗓 F 84		Months Days	Hours M	June 29,	1920 Vii	rginia
	he Marylar 286-f show	ector	10a. State 10b. County Maryland Prince G		Town or Lo	boro			032	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, If a Medical Expression must be invitible at	by Funeral Director	10e. Street and Number 11205 Cranford Dr 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	ive 12. Was Decedent Ever in U.S Armed Forces? 1 — Yes 2 M No If Yes, Give Year or Dates:		10f. Zip Code 20772 Was Decedent of if Yes, specify Cub. 1 □ Yes 2 ☒ No	an, Mexican, Pu	Un (Specify Yes or No-	ited Stat 14. Race · Ame Black, Whit Specify: Whi	CES prican Indian, e, etc.
21215-0036	within 72 hou ene. than "natura ta Medical E	Completed I	15. Decedent's E. (Specify only highest grade) Elementary/Secondary (0-12) 8	ducation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of ed)	working	o. Kind of Business/	
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, If a M	To Be Co	17. Father's Name (First, Middle, Last) Robert William Br		Name (First, Middle, Ma. Margie Foxw	den Sumame) e11				
Baltimore, Mary	0 0		19a. Informant's Name/Relationship (Carolyn Gorospe/D 20a. Method of Disposition 1X□ Burial 2 □ Cremation 3 □ 3 □ Cremation 5 □ Other (Specification 1)	ity or Town, State, 2 Oro, MD 2 Location - City or Chiltons,	20772					
Ball	permit. Pag Department: Importent: I any injury o		21. Signature of Funeral Service Lieer	Cosselle	_ We		ral Hom s Hwy.,	Montross,		A
	Physician /Medical Examiner	ner	23a. Part1. Enter the dease of comshock, or heart a ure dist only Immediate Cause 5: al disease or condition resulting in death) Sequentially list conditions.	A 1	ence of):			s diser		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence d.	ence of);					
P.O. Box 6	The law requires that the death certificate be executed take been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yelo 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of the pregnant at time of decent of the policy of the pregnant at time of the policy of the pregnant at time of the	death 3]Ectopic pregnand] Other (specify) _	y		23d. Date of del Month	ivery Day Year
	v requires that the de been signed by the a should be detached i	by	Part II. Other significant conditions of		lting in the u	nderlying cause gr	ven in Part I.	23e. Did tobac	100	o the cause of death?
Vital Records,		autopsy prior to completion								completion of cause of
of	ding Phyen. h. After this funeral di	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? Work? M. Housestigation								
Division	tel or Attendi rs after death. el Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical Exar	nysician: To the best of my know niner: On the basis of examinati and manner stated.	vledge, deat on and/or in	vestigation, in my	opinion, death o	ccurred at the time, date	and place, and due	to the cause(s)
)	5 1 M 10 0	~	29b. Signature and title of certifier 30. Name and address of person who	heman M	1 -	DO	50 52 U	199	S 17/4	-
	Sta	ate	ALI RAHIM 31. Date filed (Month, Day, Year)	JAN MD 750	1 50	RRAT	TS R	0AD 205	CLINTO	N MD2073
	Regist		AUG 1 2 2		Ø	Span	(s)			

DHMH 17 Rev 1/2001

	- 25	1 - For State Registrar	State of Maryland		artment of <i>tificate o</i>			Reg. No.	04	25363		
Physici	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death		
/Medi	cal	James Scott 4a. Facility Name (If not institution, give s	street and number)		4b. City. Town	, or Location of [Aug. 4		nty of Death	1:30 P ^M		
Examir	ier	Holy Cross Hospita				Spring			gomer	y		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Is		If Under 1 Year Months Day	r If Under 24	Hrs. 8. Date of Bin (Month, Date OCT 3	th	9. Birtho	lace (State or Foreign try) On, WV		
Director		234-54-5947 X Usual Residence of Decedent	IM 2∐F 66	Yrs.			OCT 3	, 1937	Lawt	on, wv		
yland	1. 1	10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits		
8e-fs	Director	VA Prince V	Villiam Man	assas					1 √ Yes 2 □ No			
with the	Dic	10e. Street and Number 8394 Shady Grove (lircle		10f. Zip Code	110		_	10g. Citizen of What Country? USA			
s 1 and 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. I thealth and Mental Hygiene item 27 is marked other than "natural; or items 23a or 28e-f show other treumatic event, the Modical Examiner must be notified at	Funeral		12. Was Decedent Ever in U.S	S. 13. V	1		n? (Specify Yes or No Puerto Rican, etc.)		lace - Americ			
after or Ite		1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give	1	1 Yes, specify Cl 1 □ Yes 2 🖾 N	Spe	llack, White,					
hours a tural', al	ed by	3 ☐Widowed 4 ☐ Divorced 15. Decedent's Edu	Year or Dates:	16a Deced	dent's Usual Occ	upation			BT	ack		
nin 72 In "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work dor DO NOT use ret	ne during most o	f working	16b. Kind of Business/Industry		oustry		
e filed within al Hygiene. I other then " vent, lite Ma	Com	12	Comogo (/ 40/ 0/ /	Dr	river			<u> </u>	Cab Co	ompany		
ould be fill Mental Hy arked oth	Be	17. Father's Name (First, Middle, Last) John Scott					Name <i>(First, Middle</i> ie Patters		iame)			
2 should be and Mental is marked or	Ţ0	9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2										
1 and 2 sl Health and Iem 27 is r		Cecilia M. Scott -	- Daughter	1067	76 Meado	w Grove	Manassas	, VA 20	109			
of Head		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	Central from Ctato	emetery, cren	sition (Name of matory or other p		Date		n - City or To			
permit. Pages Department of 6 mportant: If it iny injury or o	1	*4 □ Donation 5 □ Other (Specify)	Cul		Nat Ceme		-12-04	Culpe	eper ,	VA		
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licens	Bosset		oynes Fi 9 N. 3r	ineral E d Street	lome, Inc.	on, VA	20186			
		shock, or heart failure. Lie only or	ications that caused the death ne cause on each line.	. Do not ent	er the mode of o	lying, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death		
Physician /Medical		Immediate Cause (Fin*I) disease or condition resulting in death)	Laryngeal Cai							2 year		
Examiner			Due to (or as a consequ	ience of):								
E =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):								
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	ysic	1 Yes 2 No	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)					,		
F 5 5	by Ph	Part II. Other significant conditions con	ntributing to death but not resu	Ilting in the u	nderlying cause	given in Part I.	23e. Did	tobacco use c	ontribute to th	he cause of death?		
w requires been sig		Diabetes Mellitus,	Hypertension				10	Yes 2□No	3 Prob	ably 4 Unknown		
he law requires t e has been signe age 2 should be o	Completed						24a. Was	psy	prior to co	psy findings available mpletion of cause of		
- tag							perf 1 ☐ Yes	ormed? 2 XNo	death? 1 ☐ Yes	2□ No		
Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes X No	lospital: 1 ☐ Inpatient 2 🛣		25.004	Othor	f Death (Check only ing Home 5 ☐ Res		245 /0			
g Physic reference of this seral di	n; To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	" 3L DOX	njury at Vork?	28d. Describe			у)		
I or Attending Phy after death. Director: Atter this I in by the funeral d	atio	1X Natural 5 Pending 2 Accident Investigation	(Worth, Day 16ar)	Injury		Yes 2 No	>					
or Attenditter death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, offic	ce		(Street and Nu own, State)	mber or Rura	l Route Number,		
spitel nours a nerel I	edical Ce	29a. Certifier 1 X Certifying Phy	sician: To the best of my know	wledge, deat	h occurred at the	time, date and	place, and due to the	cause(s) and	manner as s	tated.		
	.0	(Check only one) 2 Medical Exami	ner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in m	y opinion, death	occurred at the time	, date and plac	e, and due to	the cause(s)		
in 24 he Fu pletel	e			29c. License number				29d. Date signed (Month, Day, Year)				
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Med	29b. Signature and title of certifier			29c. Lice	SIISO IIUIIDOI		Log. Date o.g	med (Monn,	Day, Year)		
To the Ho within 24 To the Fu	Med	Eliz-	ompleted source of death (f)	13a) /T	D	28656		August				
To the HC within 24 To the FL To the FL	Med	30. Name and address of person who co	ompleted cause of death (Item		Print)	28656		August				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 29, Lillian P. Trotman July 2004 2:30 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3600 Dennlynn Road Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🛛 F Yrs. Director 213-30-5433 73 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County rai', or items 23a or 28a-f show Examiner must be notified at MD Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 3600 Dennlynn road 21215 **USA** Funeral Pages 1 and 2 should be fited within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No Specify: Specify: black þ 3 Widowed 4 K Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturn any injury or other traumatic event, the Medical 1, 9068. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Arthur Trotman Lillian Beatrice Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice Smith/sister 3513 Lynchester Road Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sylnature of Funeral Service Licensee, Rona L. S. Va 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore, Street
Baltimore, MD 21201 mene Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIA HOURS /Medical Due to (or as a consequence of) Examiner DIABETIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, Physician/Medical ears IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ CARDIOVASCULAR 2 **12** No 1 Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□No 1□ Yes 1 Yes 2□ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € Mo Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEBALLOS ARTS-7505 OSIER DR-Suile O'DEA TOWSON, MD-21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 2 2004 Registrar

		Decedent's Name (First, Middle, Last	State of Maryland / Dep Pa PER INF G834	runcate of Death	2. Date of Death	3. Time of Dea
Physic /Medi		HARRY PARKER	TAYLOR		August_	9, 2004 7:30A
Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
		Manor Care Ruxton		TOWSON If Under 1 Year If Under 24 Hrs	La Data (Dist	Baltimore
Funeral Director		5. Social Security Number 6. Se 215-12-1577	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		ear) 9. Birthplace (State or Fo Country) Naryland
Mon		10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Li
a-f el	Director	Maryland Baltimo	re Baltimon	re		1 ☐ Yes 2
or 20	Dire	10e. Street and Number	,	10f. Zip Code	10g	. Citizen of What Country?
nust	eral	742 Overbrook Ro		21239 Was Decedent of Hispanic Origin? (S	Specify Yes or No-	USA 14. Race - American Indian,
Department of Health and Mental Hygiene "natural", or Iteme 23a or 28a-f show Important: if item 27 is marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at poice.	Completed by Funeral	1 Never Married 2 Married **Divorced**	1 X Yes 2 □ No WW I	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes XX No Specify:	to Rican, etc.)	Black, White, etc. Specify: White
mulin 72 nous area deat min no mayana 3ne ne matural, or lleme 23a or 28a-f ehow ne Medical Examiner must be notified at	npleted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation 16a. Dece (Give life.	edent's Usual Occupation e kind of work done during most of wo DO NOT use retired)	rking 16	b. Kind of Business/Industry
Hygiene.	Con	9	Pli	umber		Plumbing
Mental H Mental H Brked oth	Be	17. Father's Name (First, Middle, Last) John Taylor			me (First, Middle, Mai	
and Men Is marke	To	19a. Informant's PATE PRonship (T)	vpe. Print) 19b. Mail	ing Address (Street and Number or Ri	isy Stetse	
27 Is		Susan Taylo t Mead		Ridgely Oak Road		
of Head	li i	20a. Method of Disposition	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place)	Date 20	c. Location - City or Town, State
ant: If		1 Durial 2 Cremation 3 □1 1 Donation 5 □ Other (Specify)	Dulaney Val	lley MEm Gar 8/1:		utherville, Maryla
Department Important: I eny injury o		21 Signature of Funeral Savice Licens	len Kenakis			feld Funeral Home Inc. imore, Maryland 21212
3		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do not en	iter the mode of dying, such as cardia	c or respiratory arrest	. Approximate Interval Between
hysician		Immediate Cause (Final disease or condition	Mr. Sin			
/Medical xaminer			a. I on man	Cell Carli	ro ma 4	Onset and Deat
zammer		resulting in death)	a. Due to (or as a consequence of):	Cell Care	ro ma	The ? yea
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頭	cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	b. Due to (or as/a consequence of):	Dell Carli	no ma y	The ? Yea
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蟲	Physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that innitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d	□Ectopic pregnancy □ Other (specify)		2 3d. Date of delivery
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylan		artment o			ind M	-	giene Reg. NG. []	Oly	25366
	Physici /Medic		Decedent's Name (First, Middle, Adam Solomon Ta	nner							2. Date of De Month August	6, 20		3. Time of Death 10:40P M
	Examir	er	4a. Facility Name (If not institution,				4b. City, To			f Death			inty of Deat	
			Montgomery Hosp 5. Social Security Number		House		Rockv		e If Under 2	24 Hrs.	8 Date of Birt		tgome	
	Funeral Director		578-42-9945	1 ∑ M 2□F	70	Yrs.			Hours	Min.	8. Date of Birt (Month, Da Aug. 3	v. Year) 0, 193	3 Ne	hplace (State or Foreign untry) W York
	ס		Usual Residence of Decedent									, -,		
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	he M	Director	Maryland Montgon	nery	Roc	kville								1 ☐ Yes 2 No
	a or 2		10e. Street and Number				10f. Zip Co					10g. Citizen		
	leath ns 23	Funeral	16006 Willow La	12. Was Decede	ent Ever in U	.S. 13.			-1307	-	cifv Yes or No	Unite		ites rican Indian,
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ğ	72 hours after death with the Maryland natural', or Items 23a or 28e-f show dical Evacinet must be redified at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🔯	L No	Specify:			Spe	ocity: Wh	nite
5-0	72 h natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece (Give	dent's Usual C kind of work of DO NOT use i	ccupatione dur	on ring most	of worki	ng	16b. Kind o	f Business/l	Industry
12	within ene. than "	дш	Elementary/Secondary (0-12)	College (1-4	or 5+)							0		
d 2	e filed al Hygie other vent, tt		17. Father's Name (First, Middle, La			неач	y Equi	-	_		(First, Middle,		truct	ion
lan	ld be ental ked o	To Be	Harold James	Tanner					Eva				•	
Maryland 21215-0036	2 should be f and Mental h is marked of raumatic eve	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address (S				/ Route Numbe	r, City or To	wn, State, 2	(ip Code)
Ž,	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28e-f show or other traumatic event. If a Mind Eranine Inner ken will a Mind.		Toni J. Tanner/	Wife		1600	6 Will	ow L	ane,	Roc	kville	Mary	1and	20853
ore	of He of He fitem r oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□ Bemoval from Str		lace of Dispo	sition (Name natory or other	of			t 11,	20c. Location		
Ë	Pages ment of I ent: If its ury or o		`4 □Donation 5 □Other (Spe				Cemete		2	004		Beall:	svill:	e, Maryland
Baltimore,	permit. Pages Department of I Importent: If it any injury or o		21. Sign Funeral Service L	ensee .	. моов	03 Ro	2. Name and A ckvill ckvill	e, I	of Facility nc . [ary1	Rob 300 and	ert A. West Mo 20850-	Pumph ontgom -2805	rey Fu ery A	uneral Home/ venue
г			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cau nly one cause on eac	sed the deat h line.	h. Do not ent	er the mode o	f dying,	such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_aCare	cinoid	Syndr	ome						J	Less Than 1 Yr.
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):								
		er	Sequentially list conditions, and any, heading to immediate											
	uted d ansit	Examiner	Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that introduced events.)			•								
o,	exec an and rial-tra		resulting in death) Last Due to (or as a consequence of):											
8760,	cate be executed oblysician and the burial-transit	ical		d										
9	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical	IF FEMALE:						-					
Вох	eath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Feta	death 3	Ectopic pregr						Date of deli- Month	very Day Year
o.		ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9☐Unknow	t at time of d	eath 5L	Other (special	y)						,
σ	that the led by th detache		Part II. Other significant condition	s contributing to deat	h but not res	ulting in the u	nderlying caus	e given	in Part I.		23e. Did to	bacco use c	ontribute to	the cause of death?
Vital Records	law requires that as been signed to 2 should be det	d by	Hepatic Enceph	alopathy							1 🗆 Y	es 2 XNo	3 🗆 Pro	obably 4 []Unknown
00	law recast bee	Completed									24a. Was			topsy findings available
Re	9 - 9	mo									autop perfor		prior to c death? 1 \(\sum \text{Yes}	ompletion of cause of 2 No
ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical	====				2	6. Place	of Death	(Check only o			20110
of V	\$ S D	To	examiner? 1 ☐ Yes 2 🛣 No			ER/Outpatien	t 3 DOA	Other:	4 🗌 Nur	sing Hon	ne 5 ☐ Resid	ence 6 🟋	Other (Spec	Hospice
	ding P	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of to (Month,	Injury Day Year)	28b. Time of Injury		Injury at Work?			8d. Describe h	ow injury occ	urred	
isio	Attending r death. ector: After y the fune	Icat	2 Accident investiga 3 Suicide 6 Could no	t be Ope Place of	Injune - At he	amo form etc	M ast factors of	-	s 2 🗆 N		9f Location (S	troot and Nu	mbor or Pu	ral Route Number,
Division	l or Attencatter death Director:	ertification;	4 ☐ Homicide determin	ed 200. Flace of building	, etc. (Specify	y)	eet, factory, of	11CO			City or Tow		mber or Hu	rai Houle Number,
	Hospital	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physicien: To the ba	s of examina	wiedge, death tion and/or in	n occurred at t vestigation, in	he time, my opin	date and ion, deat	place, a	nd due to the o	ause(s) and late and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner	Stated.		29c. Li	cense n	umber			29d. Daye sig	ned (Month	. Day, Year)
	F ≯ ⊢ ŏ		Adam bus	1000 bunnal 1000 582 8/7/201						1				
	, st		30. Name and address of person w	e completed cause	of death (Item	23a) (Type.	Print)	JWI		0	0	1 1	10	
	10		Joyson Karakunne				,	Roa	ad. I	Rock	ville,	Marvla	ınd 2	0855
	Sta		31. Date liled (Month, Day, Year)	2004 32. Reg	strar's Signa	ture						y O		
	Registr	ar	HUUII	L007	7	1	Spo	chs						

			For State Registrar		State of N	/laryland		artment of tificate or			lental Hy	/giene Reg. No		Rose	05065
4	Physici /Medio		1. Decedent's Name	(First, Middle, La	,	VER		•			2. Date of Do Month August	eath Day	y Y	ear	3. Time of Death
)	Examir			ivingstor	e street and number n Terrace	#301			n Hil	1		4c. P1	County of	Geo	orge's
	Funeral Director		5. Social Security N 143-60-3 Usual Residence of	030 1	Sex 7.7	Age (In yrs. Ia 44	st birthday) Yrs.	If Under 1 Yea Months Day		Min.	8. Date of Bi (Month, D	av. Year)		COUN	place (State or Foreigntry) ginia
	Maryland -f ehow	tor	10a. State	10b. County	George's	1	Town or Lo							1	0d. Inside City Limit
	with the	i Director	10e. Street and Nur			#301		10f. Zip Code 20745				10g. Cit	izen of Wha	at Cour	itry?
36	72 hours after death with the Maryland natural; or Items 23e or 28e-f ehow deal Examinat mant be notified at	by Funeral	11. Marital Status	ed 2 Married	12. Was Deceder Armed Force 1	nt Ever in U.S s? XNo		Was Decedent of Yes, specify Cu	Hispanic C Jban, Mexic		ecify Yes or N Rican, etc.)		14. Race -	White,	
1215-0036	- 39	Completed t		15. Decedent's E lify only highest gra	ducation		(Give	dent's Usual Occ kind of work don DO NOT use reti	e during mo	ost of work	ing	16b. K	ind of Busir		
Maryland 21	should be filed within the Mental Hygiene. marked other then matic event, the Mental the	To Be Co	17. Father's Name Willie J				NOITE	-			ame (First, Middle, Maiden Sumame) gianna Turner				
	1 and 2 should I Health and Men Iom 27 Is marke- other traumatic		19a. Informant's Na Sylvia T		Type, Print) Sister)			ng Address <i>(Str</i> e 5528 Liv					or Town, Sta n Hill		
altimore,	Pages ent of nt: # II		* 4 □ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Special		te ce	metery, crem s Hill	sition (Name of matory or other p l Church	Cem	8/11			pton,	-	wn, State
Bal	Depertm Depertm Importa eny inju		21. Signature of Fu	Up. U	add	200		Name and Add Engram 21451 N	. Mai	n Str	eet Co		and,_\	۷A	23837 Approximate
	iffcate be executed / Medical physician and buysician and as the burial-transit	edical Examiner	Immediat Cause disease of condition resulting in death) Sequentially list confirmly, leading to incause. Enter Under Cause (Disease or that initiated events resulting in death)	nditions, nmediate orlying injury	b. Due to (or	a conseque as a conseque as a conseque	ence of):	cart	Jai	luri pat	liy				Interval Between Onset and Death
.О. Вох	ires that the death certificing signed by the attending die detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							y 23d. Date of delivery Month Day				,	
rds, P	w requires that been signed b should be deta	ed by Pł	Part II. Other signif	CONCOUNT	contributing to death	but not resul	iting in the u	nderlying cause	given in Par	t I.		tobacco (ne cause of death? ably 4 [Unknow
I Reco	: The law recate has be cate has be	Completed))						perf	s an opsy formed? 2 No	prio	or to cou	psy findings availabl mpletion of cause of 2 No
Vita	s certific	To Be	25. Was case referexaminer?		Hospital: 1 □ Inpa	ationt 2 E	R/Outpatier	nt 3 DOA	ther		h (Check only me 5 ☐ Res		6 Other	(Specifi	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification; T	27. Manner of Deal 1 ⊠Natural 2 ☐ Accident 3 ☐ Suicide		28a. Date of in (Month)	njury Day Year)	28b. Time of Injury	28c. In	jury at /ork? ☐ Yes 2 [□No	28d. Describe	how inju	ry occurred		al Route Number,
2	ospital or / hours after unerat Dire ly filled in b		4 Homicide 29a. Certifier (Check only	16 Certifying P	building,	etc. (Specify)	vledge, deati	h occurred at the	time, date :	and place,	and due to the	own, State	a) and mann	ner as si	tated.
	To the H within 24 To the Fo complete	Medical	one) 29b. Signature and		miner: On the basis and manner	stated.	on and/or in	29c. Lice	opinion, di	r		29d. Da	te signed (i	Month,	Day, Year)
,	7		30. Name and add	ress of person who	completed cause of	death (Item	A				h Ave				92004 ls. MD
	Sta Regist	ate rar	31. Date filed (Mor		32. Regi	strar's Signati		5 Sp	raks						

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5 sparks

		State of Maryland / Department of Health and Mei Certificate of Death		25368
	Physician		Date of Death Month Dey	3. Time of Death
4	/Medical	Walter Hills Verdier A Facility Name (If not institution, give street and number) 4b. City, Town, or Locat	ugust 11 , 200	
and the same	Examiner	Buckingham's Choice Adamstown		erick
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M onths Nonths 1 Days 1 Under 1 Year 1 Under 24 Hrs. 8. Months 1 Days 1 Under 1 Year 1 Under 24 Hrs. 1 Months 1 Under 1 Year 1 Under 24 Hrs. 1 Under 1 Year 1 Under 24 Hrs. 1 Under 1 Year 1 Under 1 Year 1 Under 1 Year 1 Under 2 Hrs. 1 Under 1 Year 1 Under	Date of Birth (Month, Day, Year))4/02/1914	9. Birthplace (State or Foreign Country) Michigan
	and **	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Manyl 1 sho	MD Frederick Adamstown		1 ☐ Yes 2 ☒ No
	or 28e	10e. Street end Number 10f. Zip Code	10g. Citizen of V	Vhat Country?
	23a c	7012 Upland Ridge Dr. 21710	USA	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Evantinar must be notified at once. To Be Completed by Funeral Director	11. Merital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U,S. Armed Forces? 1 Never in U,S. Armed Forces? 1 Never in U,S. Armed Forces? 1 Never in U,S. If Yes, specify Cuban, Mexican, Puerto Rich Yes, Sive Year or Dates:	y Yes or No- can, etc.) 14. Hack Black Specify	e - American Indian, **, White, etc.
2 0	72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Bu	usiness/Industry
2	ed within 72 hours a ygiene. or than "naturel", o it, the Madical Exan Completed by	Elementery/Secondary (0-12) College (1-4or 5+) 4 Engineer	Defense	2
9	filed v Hygie ther t ant, m		First, Middle, Maiden Sumam	
an	Mental H where off which off artic ever	John Walter Verdier Eva Louis	se Hills	
Maryland	and N e mar	19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R		
	and 2 ealth n 27 I	Brice D. Verdier (wife) 7012 Upland Ridge Dr., A		
No.	iges 1 F fter or of	1 Rurial 2 N Compation 3 Removal from State		City or Town, State
Baltimore,	it. Pa intmer intent: njury	4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 8/1 21. Signature of Tuper(I Service Licensee) 22. Name and Address of Facility Adver		dria, VA
Ba	perm Depa Impo any l	7211 Lee Hwy., Falls	Church, VA	22046
James	Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List of the one cause on each line.	espiratory arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition a. Aspiration Pneumonia resulting in death)		Days
	<u> </u>	Due to (or es a consequence of): End Stage Parkinson		Years
	o ted	b	-	10020
Ö,	e axee ian ar urial-ti	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying End Stage Dementia Cause (Disease or injury c.		Years
× 68760,	The iaw requires that the death certificate be associted at has been signed by the attending physician and page 2 should be detached for use as the burlatir insit completed by Physician/Medical Exeminer	that initiated events resulting in death) Last Due to (or as a consequence of): Hypertension d.		Years
Box	atten affor u	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did tobacco use cor	ntribute to the cause of death?
О.	as that the death certificated by the attending be detached for use a by Physician/M	Gout, Cerebral Vascular Accident, Atril Fibrillation,	1 □ Yes 2 No	3 □ Probably 4 □ Unknown
Records,	requir been s should	Acute Renal Failure, Raynaud's Syndrome	24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
<u>~</u>	The is		1 ☐ Yes 2 🔯 No	1 ☐ Yes 2 ☐ No
Ita	entifice ector, le	25. Wes case referred to medical examiner?		
of Vital	this call direction To		5 Residence 6 Oth	
- O	After funer flon	27. Manner of Death 1 12 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 1 Yes 2 No	a. Boodings from injury seedin	
Division	tal or Attending P rs after death. al Director: After t lad in by the funers Certification:	2 B Accordin	f. Location (Street and Numb City or Town, State)	er or Rural Route Number,
	To the Hospital or Attending Physician: The iaw within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and (Check only one) 13 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and place, and place and	d due to the ceuse(s) end ma at the time, date and place,	nner as steted. and due to the cause(s)
	Within To the compile	29b. Signature and title of certifier 29c. License number		d (Month, Day, Year)
	/\	Melley MD D54749	August	11, 2004
	4	30. Name and eddress of person who completed cause of teath (Item 23a) (Type, Print)	A	
		Allen Reilly, MD 801 Toll House Ave., D-1, Frederick, 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MD 21701	* * * * * * * * * * * * * * * * * * * *
	State Registrar	AUG 1 2 2004 Server B sports		

DHMH 16 Rev 6/95

Steven F. Williams Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-5165 State of Maryland / Department of Health and Mental Hygiene AKG Unpend item Registrar # 23a, 27, 28a-f, per ME, G834, 94 25 par Death Reg/No.UU 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** Steven F. Williams /Medical 9 2004 August Р 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6260 Washington Blvd. Elkridge
If Under 1 Year If Under 24 Hrs. Howard 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 1 M M 2 □ F 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) Year Months Days Hours Min 34 Yrs. Director 217-68-2314 June 18 1970 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ed other than "netural", or Items 23a or 28e-f show event, the Medical Examinar must be multiled at 1 ☐ Yes 2 X No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Crossing 8025 Mansion House 21122 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Service Technician Pool Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Williams. Harriet Smart 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8025 Mansion House Crossing, Pasadena, MD 21122 item 27 other tre Jennifer Williams 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) = 5 Department of Importent: If any injury or once. .Metro Crematory Inc. 8/11/04 Baltimore Maryland 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Funeral Service Ucense 3111 Mountain Road Pasadena MD 21122 23a. Part I. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician Cocaine Intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Discase or injut that initiated events resulting in death) Last ng physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ signed b d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? leath? XYes 2 □ No certificate Yes 2 No the Hospital or Attending Physician: 26. Place of Death (Chi ck . I. one Be 25. Was case referred to medical examiner? spital: 1 ☐ Inpa Int 2 ☐ ER/Outpatient

28a. Date of Interest 28b. Time of (Month, Jay Year) Other: 2 1XXes 2 No 4 Nursing Home 5 Residence 6 Nother (Specify) at scene 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending unknown unknown 1 ☐ Yes 2 No death. 8/9/04 investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 6260 Washington Blvd., Elkridge, MD 28e. Place of Injury - At home, farm, street, factory, office þ 4 | Homicide hotel (Specify) within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. S 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 10, 2004 completed cause of death (trem 23a) (Type, Print) wite me 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature Day, Year) State AUG 1 2 2004

Registrar

			For Stete Registrar	State of M	laryland / Dep <i>Ce</i>	artment of F		•	giene Reg. N. 0	4 25370		
	°0		Decedent's Name (First, Middle	, Last)				2. Date of De	ath	3. Time of Death		
	Physicia /Medic		Francis E. W	ieland				Aug.	Day 10	Year 2004 6:35 A M		
	Examin		4a. Facility Name (If not institution		7)	4b. City, Town, o	r Location of D			4c. County of Death		
			1002 Timber T			Tows			Bal	timore		
	Funeral		5. Social Security Number	1 J.M 2 🗆 F	ige (In yrs. last birthday) Yrs.	Months Days		Min. (Month, Da	th y, Year)	Birthplace (State or Foreign Country)		
	Director		220-05-2264 Usual Residence of Decedent	X8	34 115.			Nov.	3 1919	MD		
	land		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits		
	Man a-f sh	tor	MD Baltin	more	Towson					1 □Yes 2 No		
	th the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Country?		
	th wil	Funeral Director	1002 Timber Tr	ail Rd.		212	86		US	SA		
	r dea	nei	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H	lispanic Origin an, Mexican, P	? (Specify Yes or No Juerto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.		
36	s afte	by Fu	1 Never Married 2X Marri 3 Widowed 4 Divorced	ied 1 X Yes 2 ☐ If Yes, Give Year or Dates:	100 100	1 ☐ Yes 2 🙀 No	Specify:		Specify	white		
21215-0036	72 hours after death with the Maryland natural', or Herns 23a or 28a-f show Jisal Examires - ust be mullied at		15. Decedent			dent's Usual Occup	ation		16b Kind of Bu	usiness/Industry		
5	In 72 n "na	Completed	(Specify only highes	t grade completed)	(Give	kind of work done DO NOT use retire	during most of	f working	TOD. TURE OF DE	2011/03@11/dustry		
212	d with giene rr tha	mo	Elementary/Secondary (0-12)	College (1-4or		Maintena	nce Co	nsultant	Auton	notive		
b	e filed al Hyg othe vant,	BeC	17. Father's Name (First, Middle, I	Last)			18. Mother's	Name (First, Middle,				
<u>la</u>	ould b Menta arked	70	Frank Wieland				Carr	ie Baker				
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. itam 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", exception in all the notified at	3	19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Mail	ing Address (Street	and Number o	or Rural Route Numbe	er, City or Town,	State, Zip Code)		
	and lealth m 27 her tr		Norma Lee Wiela	and/wife	20b. Place of Disp	2 Timber	Trail	Rd., Tow	son, M	D 21204 City or Town, State		
altimore,	Pages 1 nent of H int: If ita	. 9	20a. Method of Disposition 1 □Burial 2 □ Cremation	3 Removal from State	comptany cre	matory or other place	сө)	8/14/04	20c. Location -	City or Town, State		
ţ	t. Pa rtmen rtent: njury		'4 □Donation 5 □Other (Sp		Grace U	Inited Me	thodist	Ch. Cem	. Reiste	rstown, MD		
Bal	permit. Pages Department of Importent: If it any injury or o	, ç,	21. Signature of Funeral Service	Flagle	1	^{2. Name and Addre} emmon Fu 0 W. Pad	uneral onia Ro	Home of D	Dulaney ium, MC	Valley, Inc.		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not en					Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	GOA	VGESTIVE	HEART F	ALLURE			Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):	ENDOCARD						
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9	ifficate g phys as the	edic		0.								
Box	death certificate be executed e attending physician and of for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		☐Ectopic pregnancy	1		l l	te of delivery		
	ne deat the att hed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			Other (specify)			Мо	nth Day Year		
P.0	tt tt by tac	Phy	9 Unknown		· · · · · · · · · · · · · · · · · · ·			00. 5:4.	-1			
	S 60	by	Part II. Other significant condition	ns contributing to death	but not resulting in the i	ınderiying cause giv	en in Part I.	239. Dia 10		ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown		
orc	w requires been sign should be	ompleted										
Sec.	2 2	hpl						24a. Was	osv . I	Were autopsy findings available prior to completion of cause of death?		
Vital Records,	ician: The l certificate harector, page	O						perfo 1 Yes		Yes 2 No		
Vit.	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		oth all post Oth	000	Death (Check only o		(C=Y)		
of		H-	27. Manner of Death	28a. Date of In	jury 28b. Time (now injury occurr	1-177		
ion	Attanding Ph r death. actor: After th by the funeral	atlo	1 Natural 5 ☐ Pending		Day Year) Injury		rk? Yes 2 □ No	e della dell				
Division	or Attandi after death. Diractor: A lin by the fu	ertification:	3 Suicide 6 Could r	not be ined 28e. Place of Ir	njury - At home, farm, si etc. (Specify)	reet, factory, office		28f. Location (5 City or Tox		er or Rural Route Number,		
	tator s afte al Dir ed in	Cer		ballaling, c	ote. (Speeny)				, 51410/			
	To the Hospital or Atta within 24 hours after de To tha Funaral Diracto completely filled in by th	edical	29a. Certifier 1 Certifyin (Check only one)	g Physicien: To the bes Exeminer: On the basis and manner s	of examination and/or in	th occurred at the tin envestigation, in my c	ne, date and p pinion, death	place, and due to the occurred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)		
	omple	Me	29b. Signature and title of certifier	r		29c. Licens	e number		29d. Date signed	d (Month, Day, Year)		
			> cuganson	we MD		D16	619		Augus	T 11, 2004		
n	11		30. Name and address of person	who completed cause of	death (Item 23a) (Type	, Print)		<u> </u>				
4		C	Corazon Soares,	M.D. 991	40 Franklin	Square	Dr Su	ita K. Ba	Ito ME	21226		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	40 Franklin strar's Signature	Sparker	υι. ο υ	ite K, Da	ico., IVIL	21230		
	Registr	rar	AUG 1 2 20	J4 pen	- P	goods						

			1 - For State Registrar	State of M	laryland / Dep	ertificate of		Mental H	ygiene		25371
	Dhuoisi		1. Decedent's Name (First, Middle, Last))				2. Date of D		Year	3. Time of Death
	Physici /Medio		Fr.	ederick	Emerson	Wimer	t	August			7:30 a M
	Examir		4a. Facility Name (If not institution, give	street and number)		r Location of Death	n	4c. Co	unty of Death	
			505 Upland Road			Pikesvi				Ltimore	<u> </u>
	Funeral Director		5. Social Security Number 6. Security Number 217-05-6070	14 0 F	ge (In yrs. last birthda) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, D	irth Say, Year) = 31, 1	Coul	olace (State or Foreigr ntry) ryland
	land ow		10a. State 10b. County		10c. City, Town or I	ocation				1	10d, Inside City Limits
	Mary 1 sh	ō	Maryland Baltimor	e	Pikesvil.	le					1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	h witl		505 Upland Road				21208	3	United	l State	
	deet	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	Was Decedent of H				Race - Americ	can Indian,
036	n 72 hours after deeth with the Maryland "natural", or Itama 23e or 28e-1 show gottes! Exeminet must be notitled at	by Fu	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No		o nicali, etc.)	1	Black, White, ec <i>ify:</i> Whi			
5-0	72 ho	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a. Dec	edent's Usual Occup	ation	kina	16b. Kind o	of Business/In	dustry
2	C 20	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work done DO NOT use retired	daning most or wor	Killy		r Brus	h
21	be filed withlr ital Hygiene. id other then	ပိ	12th	-	Sales	sman			Compa		
pu	be fit ital H id oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan			•	
<u>Y</u> a	should be ind Mental marked c	10	Walter C. Wimert					Louise			
Maryland 21215-0036	nd 2 :		19a. Informant's Name/Relationship (Ty Kathryn Wimert	(Wife)		ing Address (Street Upland Ro					Code)
J'e	of Hee		20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place	ce)	Date	20c. Locati	on - City or To	own, State
Ĕ	Pages nent of I int: if its iry or o		1 X Burial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State				13, 20	04 Pik	esvill	e, Marylan
Baltimore,	permit. Pages Depertment of I Important: If its any injury or o	i	21. Signature of Funeral Service License	^		22. Name and Address R728 Liber	ss of Facility $ {f Lo} $	ring By	ers Fu	neral 1	Directors
			23a. Part1. Enter the disease, or compli	ications that cause	d the death. Do not er					1111 21.	Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Chren		vetua	Lung s)			Interval Between Onset and Death
		ē	Sequentially list conditions, if any leading to immediate		a consequence of):						
	ate be executed hysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	en ar		resulting in death) Last		a consequence of):						
8760,	ate be shysici the bu	Icai		j							
9	rtifica ng ph as th	e	IF FEMALE:								
P.O. Box	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i>				Date of delive Month	ery Day Year
	res thet igned b	by PI	Part II. Other significant conditions con	ntributing to death t	out not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use c	contribute to th	e cause of death?
rds	quire n sig uld bi		Atral Firm	china				1/2	Yes 2□No	o 3 🗆 Prob	ably 4 Unknown
Records,	sw requires been si	Completed						24a. Was	an 24	tb. Were autor	psy findings available
æ	e = e	E o							ormed?	death?	npletion of cause of
Vital		0	25. Was case referred to medical				26. Place of Deal	1 ☐ Yes		1 🗆 Yes	2 No
<u> </u>	ysician: is certific director,	To B	examiner?	lospital:	ent 2 ER/Outpatie	nt 3 DOA Othe	er: 4 Nursing Ho			Other (Specify	()
J Of	Attanding Physician: r death. sctor: After this certific by the funeral director,		27. Manner of Death	28a. Date of Inju (Month, Da	ury 28b. Time (of 28c. Injun	at	28d. Describe	how injury occ	curred	,
ior	ath. r: Af	atic	1. ■Natural 5 □ Pending 2 □ Accident investigation	(Monan, Ba	iy roar) injury		Yes 2 □ No				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, et	jury - At home, farm, s tc. (Specify)	reet, factory, office		28f. Location (City or To	Street and Nu wn, State)	ımber or Rurai	l Route Number,
	To the Hospital or within 24 hours efter To the Funerel Dir completely filled in	Medical C	29a. Certifier Check only one) Certifying Phys	sician: To the best ner: On the basis of and manner st	of my knowledge, dea of examination and/or in ated.	th occurred at the time	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and place	manner as sta	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date sig	ned (Month, L	Day, Year)
)	> 1- 0		cen u	cee.	n.n.	D 1	2085		Ausus	1 10	2004
			30. Name and address of person who co	mpleted cause of o	death (Item 23a) (Type				,		
0			Alles J. Ch.				Lours	Reco	2	1133	
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signature						
201	Registr		AUG 1 2 2004	Sener	rar's Signature	boards					
DH	MH 17 Rev 1/20	J01	MUU A IN LUST	4	1	7					

ORIGINAL

	FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN REG. NO.	E 200	4 25372				
	1. DECEDENT'S NAME (First, Middle, La.	st)	111 1	50		2. DATE OF DEATH	Y 7 YEA	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (ALK In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	d064	IRTHPLACE (State or Foreign				
	239 46 8956	1 M 2 □ F 7:	3 YRS.	MONTHS DAYS	HOURS MIN.	8/14/30	C	N.C.				
æ	9a. FACILITY NAME (If not institution, given BON SECOUR			9b. CITY, TOWN C	R LOCATION OF LOCATION OF	DEATH	9c. COUNTY C	OF DEATH				
CTOR	RESIDENCE OF DECEDENT											
OIRE	MD.	NTY	10c. CIT	y, town or locat BAL'_{\cdot}	IMORE			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
	2719 LAU	RETTA AVE.	III S ADMED	12 WAS DEC	21223	ANIC ODICINO (CIII. V	US	SA RACE — American Indian,				
BY FUNERAL	1 Naver Married 2 Merried 3 Widowed 4 Divorcad	FORCES? 1 YES	1 YES 2 XNO			ANIC ORIGIN? (Specify Yea can, Puerto Ricen, atc.) city:	Black, Whita, atc. SpeciBLACK					
	15. DECEDENT'S E (Specify only highest gr	ade completed)	16a. DECEDENT'S (Give kind of title. Do NOT us	USUAL OCCUPATION work done during mose retired.)	N st of working	16b. KIND OF BUS	INESS/INDUSTF	RY				
COMPLET	Elamentary/Secondary (0-12)	Collega (1-4 or 5+)		IOREMAN		BETHL	EHEM S	STEEL				
BE CO	17. FATHER'S NAME (First, Middle, Last) JAMES W	ALKER SR.				NAME (First, Middle, Maiden OLET WALK)						
2	19a. INFORMANT'S NAME (Type/Print) VIOLET G. W	ALKER		LAURE'		E. BALTO.						
	20a. METHOD OF DISPOSITION 15 Burlal 2 Cremation 3 R 4 Donation 5 Other (Specify)		PLACE AND DATE			8/14/04	WOODI	or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		EST		FACILITY S. FUNERA W PL. BAL'						
	23. PART i. Enter the diseasas, of ahock, or heart failure	or complications that caused re. List only one cause on e		not enter the mo	de of dying, su	ich as cardiac or raspi	ratory arrest,	Approximate interval Batwaen				
	immediate cause (Final disease or condition resulting in death) a. CARDIO DUIM GRARY ARMEST, ACUTE Due to (or as / consequence of): Sequentially list conditions, Due to (or as / consequence of): Sequentially list conditions, Due to (or as / consequence of):											
z	W-00.	- SEVERE	MET	1 POLICE	Aci	Dosis						
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	A	F):								
CERTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O		>							
	resulting in death) LAST	. DEPTI	C 51	to CK								
SAL	PART II. Other algorificant condit	ions contributing to death b	ut not resulting	in the underlying	g cause givan i	n Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
	CONDESTIVE	HOURE F	THRMI	/		1 TYES 2	XNO	COMPLETION OF CAUSE DF DEATH?				
Σ	DID TOBACCO USE CON				UNCERTA	IN		1 TYES 2 NO				
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:								
HYS	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpatiant 2 ER/Outp	28b. TIN	IE OF 28c. INJ	URY AT	28d. DESCRIBE HOW II	NJURY OCCURE	D				
BY P	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 1	RK? /ES 2 NO							
	3 Suicide 6 Could not 4 Homicide datarmined		— At home, tarm, cify)	street, factory, offic	•	281. LOCATION (Street e City or Town, State)	ind Number or Ru	ıral Route Number,				
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHOTOLOGICAL EXAM		ise(s) end mannar es stated.									
10 BE (296 SIGNATURE AND TITLE OF CERTI	n MD, MEDICA	LSTAF		29c. LICENSE N	129)	≥ OS	NED (Month, Day, Year) - 07-2054				
		TIMORE ST.	BON So	Ceves He	svite,	Baltimore	MD.	21223				
	31. DATE FILED (Month, Day, Year) ALIG 1 2 2	2004 Seminary Sign	LATURE &	Low		/						
	Add # 44 c	/		1-1-1-1				DHMH-16 Rev 1/89				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month UGIUST Year WHITEHEAD 02.32 PM 06 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BAUTINORE HOSPITAL 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M & F 36 Yrs MD10b. County 10c. City, Town or Location 10d. Inside City Limits

BALTIMORE

10f. Zip Code

1 ☐ Yes 2 No

HOMEMAKER

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

21225

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 - For State Registrar **Physician** TAMIKO /Medical Examiner HARBOR 5. Social Security Number **Funeral** 218 84 4011 Director Usual Residence of Decedent with the Maryland 10a State r than "natural", or itema 23a or 28a-f show the Medical Examinat must be notified at Director MD. 10e. Street and Number 2812 POTEE ST. death 11. Marital Status Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Event in 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Be GEORGE WHITEHEAD JR. 19a. Informant's Name/Relationship (Type, Print) important: if any injury or once. permit. Page Department **Physician** disease or condition resulting in death) /Medical Examiner Examiner attending physician and I for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?

1002 SOUTHRIDGE RD. BALTO. MD. JANICE ROBINSON MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WESTERN STAR 8/13/04 CATONSVILLE, geral Serviçe Licensee ESTEP BROS. PL. BALTO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SEP515 Immediate Cause (Final Due to (or as a consequence of) +1V Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): RENAL DISEASE ENDSTAGE that initiated events resulting in death) Last Due to (or as a consequence of): PNEUMONIA 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery

4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

12. Was Decedent Ever in U.S. Armed Forces?

☐Yes 2₩No fYes, Give X

College (1-4or 5+)

0

Year or Dates:

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed? 202 No 1 Yes e of Death (Check only one)

Month

1 Yes 2 No

10g. Citizen of What Country?

14. Race - American Indian,

BLACK

21228

Approximate Interval Between Onset and Death

DAYS

Year

Day

Black, White, etc.

USA

Specify:

HOME

18. Mother's Name (First, Middle, Maiden Surname)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

JANICE R. ROBINSON

16b. Kind of Business/Industry

NON STE	ELEVAT10	N MYO	CAR	DIAL
INFARCTION	J			
25. Was case referred to medical				26. Place
examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatient	3□ DOA	Other: 4 N

ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1 [Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 5 Pending investigation Injury М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

3 Ectopic pregnancy

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AUGIUST 06 2004 RES 001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOUTH HANDVER STREET, BALTIMORE, MD21225

State Registrar

31. Date filed (Month, Day, Year) DUG 1 2 2004

JANAKI DEEPAK

32. Registrar's Signature

HARBOR HOSPITAL 2001

DHMH 17 Rev 1/2001

signed by the a

page 2 s

director,

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Certification:

Medical

certificate

this

After

n 24 hours after death.

• Funeral Director: A

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within 2

the Hospital or Attending Physician:

0

death.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year WILLIAMS HER BERT 2:45PM AUGUST 04 1004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE, MARYLAND BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3-12-1952 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 9. Birthplace (State or Foreign 1X M 2∏ F MARY LAND Yrs. Director 218-54-4358 52 Usual Residence of Decedent death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show s 23a or 28e-f show Director t√□Yes 2□No BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1526 N. BROADWAY ST. 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after dealth and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2X No The Medical Exam þ 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-LABORER -0-STEEL markad other traumatic evant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBERT WILLIAMS SR. ပို CLARA ALSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 N. BROADWAY ST. BALTIMORE, MARYLAND 21213 SHIRLEY BETHEA(SISTER) itam 27 i other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State **≒** 5 Department of Important: If any injury or METRO CREMATORY 8-11-2004 ^¹ 4 □ Donation 5 Other (Specify) BALTIMORE, MARYLAND HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. uneral Service Licepsee JONATHAN D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 2 No Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death Check onl one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tyes 2 XNo 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after death death 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Funaral (Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-DOD MD August 4, 2004 ss of person who complited cause of death (Item 23a) (Type, Print) RIZWAN HAR, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, 4940 EASTERN AVENUE, BALTIMORE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 21224 Registrar 2 2004

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma			rtment of H		ind Me		giene	L.	25375	
	sicia		1. Decedent's Name (First, Middle, Las Betty G.	Zolle	r				٨	Date of Dea Month	ath	Year	3. Time of Death L2:50 A. M	
	ledic amin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location o		109031	4c. County		incole l	
Fune			5. Social Security Number 6. Se	M 2XF	(In yrs. last bir		If Under 1 Year Months Days	If Under 2 Hours		Date of Birtl (Month, Day	h (Year)	9. Birth Cou	place (State or Foreign untry)	
Direc		-	Usual Residence of Decedent		83 10c. City, Towi	Yrs.	artion		J	an. 12	1921		MD	
Manyla R-f shov	in the case	tor	Maryland Anne Ar		TOC. City, Town	n or coc		thicur	n				10d. Inside City Limits 1 ☐ Yes 2 🗷 No	
with the	N De Uo	i Dire	10e. Street and Number 307 Darlene Avenu	e			10f. Zip Code	21090			10g. Citizen of W		untry?	
Dariffill (1976), Ividity Italia 4 (4 13-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23e or 28a-f show in the contract of the contract o	ARTERIA DE	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1	Vas Decedent of Hi Yes, specify Cubal	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	14. Race Black Specify	k, White	ican Indian, , etc. ite	
within 72 hou iene.	INSTANCED OF	Completed	15. Decedent's Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+	eted) (Give kind of work done during most of working life. DO NOT use retired)							b. Kind of Business/Industry Household		
y railed build ba filed Mental Hygi arked other	atic event,	To Be C	17. Father's Name (First, Middle, Last)	Giles				18. Mother			Maiden Sumam ler	э)		
and 2 sho	m renum		19a. Informant's Name/Relationship (7 Harry A. Zoller	урв, Print) (spouse)			g Address (Street a Darlene 1						ip Code)	
Pages 1 gnent of He	ry or our		20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		cemeter	ry, crem	sition (Name of patory or other place ematory		Aug.Dat 200		20c. Location - A		own, State Maryland	
permit. Pages Department of Important: If i	any inju		21. Signature of Funeral Service Licen	2		22.	Name and Addres	s of Facility	y S	tallin	gs Funer	ral l	Home,P.A.	
Dhysisi	ion		23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final	one cause on each line	لىل			g, such as o	cardiac or r		rest,		Approximate Interval Between Onset and Death	
Physici /Medi Examir	cal		disease or condition resulting in death)	a. Due to (or as a	_ ` `	_	Ivtery							
tad		Examiner	Sequentially list con flicins fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
ate be executed by sician and the buriel tracer	e Durial-tra	icai Exai	that initiated events resulting in death) Last	Due to (or as a	consequence	of):								
death certifical attending physical	use as in	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy									23d. Date of delivery		
the death	acried for	nysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti			Other (specify)	·			Mon	th	Day Year	
wraquires that the desbasen signed by the a	90	ρ	Part II. Other significant conditions of	ntributing to death but	not resulting in	n the un	derlying cause give	n in Part I.				ibute to t	the cause of death? bably 4 Bunknown	
0 80	V	Completed								24a. Was a autop: perfor	sy p med? d	Vere autorior to co eath?	opsy findings available ompletion of cause of 2 No	
ysicien: The secretificate	director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ☐ ER/Ou	itpatient	3 DOA Othe			Check only or	n <i>e)</i> ence 6 □Othe	ır (Speci	fy)	
nding Physics.			27. Many er of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. 7	Time of njury	28c. Injury Work M 1 🗆 Y	rat ⟨? Yes 2 □ N		d. Describe h	ow injury occurre	ed De		
al or Atte	g E	Certification:	3 Suicide 6 Could not be determined	28e. Płace of Injur building, etc.	y · At home, fa (Specify)	ırm, stre	et, factory, office		28	Location (S City or Town		r or Rur	al Route Number,	
To the Hospitel or Attending within 24 hours after death.	completely med	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exem	rsicien: To the best of iner: On the basis of e and manner state	xamination an	e, death	occurred at the tim estigation, in my op	e, date and pinion, deat	d place, and h occurred	d due to the c at the time, d	ause(s) and mar date and place, a	ner as s	stated. to the cause(s)	
To the To	duoo		29b. Signature and title of certifier	Wul	, VI	MI	29c. License	number 365		1	29d. Date signed 4 ugust	(Month,	Day, Year)	
`	10		30. Name and address of person who co	ompleted cause of dea	ath (Item 23a) ((Туре, Р	Print) Spital	Dviv	e, Gl	en B	urnie,	11), 21061	
Reç	Star gistra	e ar	30. Name and address of person who compared to the state of the state	32. Negistrar	's Signature	9	Sporks	/						

			For State Registrar	State of Ma	aryland				ealth a Death	and Me	ental Hy	/giene Reg. N) n n l	2537	5
	Physici /Medio	al	1. Decedent's Name (First, Middle, Las	BORD	WSK	1	4h Cih.	T	Lacation		2. Date of D Month	10	Year 2004	0	th M
	Examir Funeral	er	4a. Facility Name (If not institution, give 5. Social Security Number 6. S	POSPITAL	e (In yrs. las	t birthday)	If Unde	1 Year	If Under 2	& R€ 24 Hrs.	8. Date of Bi	irth	N/A	hplace (State or Fo	reign
K	Director		Usual Residence of Decedent	MM 2□F	85	Yrs.	Months	Days	Hours	Min.	(Month, D IOV . 2	20, 1	918 MA		
	he Marylar 28a-f show	ector	MD • 10b. County MD • N/A		10c. City,	LTI	10RE	o Code				10g Ci	tizen of What Co	10d. Inside City Li	
	3a or	i Di	813 S. ANN ST	REET				2123	1			rog. Or	U.S.A	,	
5-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show dreal Examinar must be indified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 XYes 2 If Yes, Give Year or Dates:	No	1		dent of Hi ocify Cuba	spanic Orig n, Mexican	gin? (Spec i, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Ame Black, Whit	rican Indian,	
21215-0	C 0	ompleted	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or		life.	dent's Usu kind of wi DO NOT L	ork done d ise retired,	luring most)	t of workin	g		(ind of Business HIPPIN		
Maryland 2	be file ital Hyg id othe event,	To Be C	17. Father's Name (First, Middle, Last) JOHN ZBOROWS						MAR	Y D	(First, Middle	Maider	Sumame)		
	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (HERB ZIENTAK/F) 20a. Method of Disposition			731	S. A	ANN me of	STRE	ET, B		ORE	MD. 2 ocation - City or	1231	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Section 21. Signature of Funeral Section 22.	y)	1	Y RC	SAR	Z		8/13				E, MARYL	ΔĬĨD
Ba	Dep firm any		23a. Part1. Enter the disease, or com	20 Aris	t the death		901	EAS	I'ERN	AVE	NUE, E	BALT	RAL HO IMORE,	ME MD. 2123 Approximate	11_
	Physician /Medical Examiner portion and p	Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	a conseque	nce of):	d	0/16						Interval Betweer	
ls, P.O. Box 68760	death certificate e attending phy d for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of	d	2 □ Fetal d t time of dea	eath 3[th 5[⊒Ectopic p □ Other (s underlying	pecify)	en in Part I.				23d. Date of de Month use contribute to	Day Year	-
Records,	The law requires that the ate has been signed by th bage 2 should be detache	Completed									24a. Wa	s an opsy formed?	24b. Were a prior to death?	utopsy findings avail completion of cause	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death	(Check only		75.00	20110	
of	ng Phys Iter this	tion; To	1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Inju		R/Outpatie 8b. Time o Injury		28c. Injun Work	4 🗆 NU	2	ne 5 ☐ Res 8d. Describe		6 ☐Other (Spe	cify)	
Division	al or Attendi s after death. hi Director: A	Certification;	3 Suicide 6 Could not be determined	280. Place of in	jury - At hom tc. (Specify)	ie, farm, st	reet, facto	ry, office		2	8f. Location City or To			ural Route Number,	
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	(Check only 2 Medical Examone)	nysician: To the best miner: On the basis o and manner st	f examinatio	edge, deat in and/or in	u continutio	a in mu as	cipion don	th annurer	d at the time	data an	d alaca and div	to the eques (a)	
	To To To To To To To To To To To To To T	W	29b. Signature and title of certifier	Cost,	MO		29	C. License	12C	. 3.	7	29d. Da	JG (E	th, Day, Year) 2006 2006	7
d	1,		30. Name and address of person who all the state of the s	SMA, F	death (Item 2 V) rar's Signatu	39	Print)	PAC	JL F	DAR.	E B	MI	TIRE, I	10 S150	2
	St Regist	ate rar	St. Date med (worth, Day, Aug. 1	2 2004 Pagist	al solunatu	2000	13	14	och	1					

		State of Maryland		rtment of h		Mental Hygie	2001	25277
		Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
Physici		John H. Armstrong				July 28	Day 2004	7:00 P M
/Medi Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	r Location of Dea	th	4c. County of Dea	ath
LAUIIII		Laurel Regional Hospital		Laur	e1		Prince Ge	eorge's
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birth	9. Bi	rthplace (State or Foreign
Director		218-34-6357 18M 2 F 83	Yrs.	Widthals Days	110010	Nov. 18,	1920 h	lew York
pu ,		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loc	cation				10d. Inside City Limits
arylan show	7							1 □ Yes 2 No
ha M 28a-f	Director	Md. Montgomery S 10e. Street and Number	ilver	Spring 10f. Zip Code		100	Citizen of What C	ountry?
with					901	1.09	U.S.A.	
be filed within 72 hours after death with the Maryland tal Hygiene. Ide dyfer then "naturel", or Items 23a or 28s-f show event. The Modical Examine rousing an unitied at	Funeral	10214 South Moor Dr. 11. Marital Status 12. Was Decedent Ever in U.S	5. 13. V			Specify Yes or No-	14. Race - Am	
Item Item	un.	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1943	3 If	Yes, specify Cuba	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
irs af	by F	If Yes, Give 3 ■ Widowed 4 □ Divorced Year or Dates: 194	_ 1	I□Yes 2■No	Specify:		Specify:	Vhite
2 hou		15. Decedent's Education	16a. Deced	ient's Usual Occup	ation	161	o. Kind of Busines	s/Industry
nin 72	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. E	kind of work done OO NOT use retired	during most of wo d)	orking		
d with	Completed	4	Me	echanica1	Engine	er U.	.S. Navy	Dept.
othert,	0	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Mai	den Sumame)	
VICITY COLOR A LATE 12 Should be filed within hard Mental Hygiene. 7 Is marked other then " reumatic event, ITE MA.	To B	Alfred Armstrong			Ruth	Voor	rhees	Step
SIC, MICH YICH as 1 and 2 should b of Health and Menit fitem 27 ie markad rother treumatic e		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Number, C	ity or Town, State,	Zip Code)
and 2 and 2 ealth a n 27 le		Mary Ellen Curtis (Daughter)	7038	Heathfie	eld Rd. I	Baltimore,	Md. 212	212
othis other		CO	ace of Dispos	sition (Name of natory or other plac	ce)	Date 200	c. Location - City o	r Town, State
Pag High		1 ☐ Burial 2 Macromation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Cham	bers (Crematory	7/:	31/04 R	iverdale,	Md.
parmit. Pagas 1 Department of H Importent: If ite any Injuryer ott once.		21. Signature of Funeral Service Licenses	22	. Name and Addre	ss of Facility Ch	ambers Fund	eral Home	e & Crematori
		Thomas S. Chamber	- 580	01 Clevel	land Ave	. Riverdal	e, Md. 20	737
*		23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory arrest		Approximate Interval Between
Pnysician		Immediate Cause (Final	Heari	t Failur	ro			Onset and Death 48 Hours
/Medical	ı	disease or condition resulting in death) Congestive Due to (or as a consequence of the content		t laiiui				10 10020
Examiner		Anemia						48 Hours
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ence of):					
uted d ansit	Examiner	Cause (Disease or Injury that initiated events c. Metastatic	Adeno	caranoma	of the	Colon		3 Months
exac an an rial-tr	EX	resulting in death) Last Due to (or as a consequ	ence of):					
Certificate ba exacuted nding physician and use as the burial-transit	dlcal	d						
tifficat ng phy as the	led						1	
h cer endir	N/CI	IF FEMALE: 23b. Was decedent pregnant 1□Live birth 2□Fetal		Ectopic pregnancy	v		23d. Date of d	,
death death e atter	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year
that the	hys	9 Unknown						
wrequires that the death certific bean signed by the attending I should be detached for use as	by P	Part II. Other significant conditions contributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac		to the cause of death?
w requires the requires should be	ed	Atrial Fibrillation				1 🗌 Yes	2 3 No 3 ☐ F	Probably 4 Unknown
law re as be	Completed	Urinary Track Infection				24a. Was an autopsy		autopsy findings available completion of cause of
~ •	E					performe	d? death?	es 2 No
VITAL P iiclen: Th certificate rector, pag	O	25. Was case referred to medical			26. Place of De	eath (Check only one)		
99	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 I	ER/Outpatien	nt 3 DOA Ott	ner: 4 Nursing	Home 5 ☐ Residence	e 6 □Other (Sp	ecify)
	L.	(Month Cou Voor)	28b. Time of Injury	28c. Injui Wo	ry at	28d. Describe how	injury occurred	
DIVISION I or Attending after death. Director: Afte	atio	2 Accident investigation	,,		Yes 2 ☐ No			
VIS Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:					H		
ospi hour uner ly fill		29a. Certifier (Check only 1 Certifying Physician: To the best of my know 2 Medicel Exeminer: On the basis of examinat						
To the Hos within 24 h To the Fur completely	ledical	one) and manner stated.						
To t To t	Σ	29b. Signature and tife of certifier		29c. Licens	se number	29d	. Date signed (Moi	nin, Day, Year)
19+1		· unstuden	W		51817	J1	uly 29, 2	2004
, , ,		30. Name and address of person who completed cause of death (Item						
		Eric B. Lieberman MD. 10313 Ge		Ave. #30	08 Silve	r Spring,	Md. 20902	
	ate	31. Date filed (Month, Day, Year) ALIG 0 2 2004 32. Registrar's Signat	ture /4	Sparks				
Regis	rar	AUG 0 2 2004	1	popularion	F			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 31, Day **Physician** Rosemary Elizabeth Lorna Anderson 2004 9:03 P^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 88 220-48-0795 Director Feb. 22, 1916 Canada Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exer in at must be notified at 1 ☐ Yes 2 ☑ No Maryland | Montgomery Bethesda 288-1 Direct 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5 9707 Old Georgetown Road 20814 tems 23a Canada Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 Yes 2X No. Specify: White à 3 ☑ Widowed 4 ☐ Divorced 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Pepartment of Health and Mental Hygie sportent: If item 27 is marked other to y injury or other treumatic event, Its 28. Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Laurence Savage Cicely Noel French 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Laurence Anderson/Son 2617 Exeter Road, Cleveland Heights, Ohio 44118 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State August 4, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2004 Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
7557 Wisconsin Ave., Bethesda, MD 20814-3501 Depar Impor any in M00198 23a. Part1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Embolism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a y leading Lammadata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medicai attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Yes 2 X No 1 Yes 2 🗆 No Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 02625 August 2, 2004 30. Name and ad less of person who completed cause of death (Item 23a) (Type, Print) 8218 Wisconsin Avenue #103, Bethesda, Maryland 20814 Ava A. Kaufman, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene

					arylana i	•	ificate of		F	leg. Nd.)	01.	25270
1	Physic /Med Exam	lical	Decedent's Name (First, Middle, I HLLDA Fecility Name (If not institution, g)	ATKIN	50N	,		4b. City, Town, or	2. Dete of Dee Month 7 Location of Deeth	Day	Year O 4 of Death	3. Time of Death
and a			BRIGHTON	GARDI	ENS			BETHE		Mo	V 160	MERY
P	Funera Directo		5. Social Security Number 6. 265-38-8394 Usuel Residence of Decedent	4 D 14 OKT E	e (In yrs. lest i		If Under 1 Year Months Days			910	9. Birthpl Count Flor	ace (State or Foreign ry) Lda
	puel s		10a. State 10b. County		10c. City, To	wn or Loca	tion				10	Od. Inside City Limits
:	th with the Meryler 23s or 28s-f show ust be notified at	tor	MD Montgome	ery	North	Beth	esda					1 ☐ Yes 2 ☐ No
	4 28 th	Director	10e. Street end Number				10f. Zip Code		1	0g. Citizen of \	What Count	ry?
,	ath w		5550 Tuckerman La					852		USA		
21215-0020	72 hours after death with the Merylend natural; or items 23a or 28a-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ◯ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U,S. No		s Decedent of es, specify Cub		Specify Yes or No- rto Rican, etc.)		e - America ck, White, e	
2-0	72 hours "natural", ndical Exp	eted	15. Decedent's (Specify only highest g	Education rede completed)	16	Se. Deceder	nt's Usual Occu	pation during most of wo	orkina	16b. Kind of Bu	usiness/Ind	ustry
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an	should be filed within and Mental Hygiene. I merked other than umatic event, the M	To Be	Benjamin Caruther	•					e Lee Mob		,	
Σ	2 m m	-	19a. Informant's Name/Relationship Lexa Comstock/nie						urel Route Number Livingst			Code)
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Balti	permit. Pag Depertment important: it any Injury o		21. Signature of Funeral Service Lice			22. N	lame end Addre	ess of FacilityH11	nes Rinal e Ave Sil	di Fune	ral F	lome Inc.
			23a. Part1. Bifter the disease, or conshock, or heart failure. List onl	inplications that caused y one cause on each lin	the death. Done.	o not enter t	the mode of dyi	ng, such as cardia	c or respiratory arr	əst,		Approximate Interval Between Onset and Death
J.	Physician /Medical Examiner		Immediate Ceuse (Fina! disease or condition resulting in death)	еСа	edia	e /	free	4				3 Minute
		Je		1/2 00	Due to (or as	a conseque	nce of):				İ	1 have
	cate be executed physician end the buriel-trensit	Examiner	Sequentially list conditions,	b	Doe to (or es a	conseque	nce of):				1	nam
90,	cian e		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events	pn	eum	one	a				1	2 haues
68760,	physic the t	edicai	that initiated events resulting in death) Last		Due to (or as e	consequer	nce of):					
×	certifica ding ph use es t	- 5		d. CO	PD							
Вох	d for use	iciar	Part II. Other significant conditions	contributing to death by	it not resulting	in the unde	dvina cause di	von in Part I	23h Didto	hacco uso cor	stribute to	the cause of death?
Р.	res met me de igned by the a be deteched i	by Physician/I	Facts. Street agrinoant conductions	contributing to death be	A not resulting	in the unde	sitying cause gr	ven in Fait i.		es 2 No		/
Records,	been s	Completed b							24a. Was e	n autopsy ned?	avai	e eutopsy findings lable prior to pletion of cause eath?
Œ	0 - 0	E							1 □ Ye	s 20 No	10	Yes 2□ No
	ysician: In is certificate director, par	Be	25. Wes cese referred to medical examiner?					26. Place of Dea	ath (Check only on	θ)		
o to	this ce	2	1 Yes 2 No		nt 2□ER/C	Dutpatient	3LI DUA		fome 5 ☐ Reside	nce 6 DOthe	er (Specify)	
ט ב	frer th uneral	i.i	27. Manner of Deeth 1 ■ Naturel 5 □ Pending	28e. Date of Injur (Month, De)	Year) 28b.	. Time of Injury	28c. Inju Wo		28d. Describe ho	w injury occurr	ed	
5	to the Hospital of Attending Provincent: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigetic 3 Suicide 6 Could not 4 Homicide determined	be One Place of Init		farm, street		Yes 2□No	28f. Location (St. City or Town	reet and Numb , State)	er or Rural	Route Number,
	n 24 hours Funeral	edicai C	29a. Certifier 12 CertifyIng P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination a	ge, deeth oo ind/or invest	curred et the ti	me, date and place opinion, death occu	a, and due to the ce urred et the time, da	use(s) and ma ate and place, a	nner as sta and due to t	ted. he cause(s)
1	within 2 To the	M	29b. Signature and title of certifier	, ()			29c. Licens			d. Date signed	(Month, D	ay, Yeer)
	1		A. V	Yangs	2 MI	>	DZ	9883		7/20	5/0	7
	,	ĺ	30. Neme end address of person who	completed ceuse of de	eeth (Item 23e	(Type, Prin	nt)			•		
	St	ate	Andrew Panagos 64 31. Date filed (Month, Day, Year)		ge Dr	STE 2:	10 Beth	esda MD 2	20817			

DHMH 16 Rev 6/95

		•	For State Registrar	State of Marylan		artment of H rtificate of L			giene Rog. No?	04	25380
	Physici /Medic		Decedent's Name (First, Middle, Last) Philip H. Abelson					2. Date of De Month 8-1-2	2004	Year	3. Time of Death 4:30 P. M
	Examin	er	4a. Facility Name (If not institution, give s Suburban Hospital 5. Social Security Number 6. Sex		last hirthday)	4b. City, Town, or Bethesda	If Under 24 Hrs.		Mont	gomer	y place (State or Foreign
	Funeral Director			M 2□F 91	Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 4-27-1	913°	Was	shington
	e Maryland ta-f show	ctor	D. C. None		, Town or Lo						10d. Inside City Limits 1½ Yes 2 □ No
	ath with th	ral Director	10e. Street and Number 4244 50th St.				0016		U.S.	Α.	
036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show he Modical Exertire mast be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2幫 No	spanic Origin? (Sin, Mexican, Puerti Specify:	pecify Yes or No o Rican, etc.)	В	tace - Ameri Black, White, cify: White	etc.
21215-0036	s 1 and 2 should be filed within 72 hours I Health and Mental Hygiene. Itam 27 is marked other than "natural; other traumalic event, the Modical Exe	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 5+	(Give	dent's Usual Occupa kind of work done o DO NOT use retired, LCIST	luring most of wor	king	16b. Kind of		for Adv. Sci
Maryland 2	should be filed within of Mental Hygiene. marked other than matte event, the M	To Be C	17. Father's Name (First, Middle, Last) Andreas Abelson				18. Mother's Nam Eller	ne (First, Middle, 1 Hauge			
	s 1 and 2 should of Health and Men item 27 is marke other traumatic	7. S.	19a. Informant's Name/Relationship (Type Ellen Cherniavsky	- Daughter	1052	ng Address (Street a 28 Georgia		llver Sp	ring, l	MD 209	002
Baltimore,	permit. Pages 1 Department of He Important: If iten any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Ri ' 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei	esition (Name of matory or other place ort Crem.		Date 5-04	20c. Locatio Alexan		
Ball	Departiment Departiment Departiment Departiment Departiment Depart	y 18	21. Signature of Funeral Service License License 23a. Part 1. Enter the disease, or complise shock, or heart failure. List only on	Cospiler	51	2. Name and Addres	sin Ave.	seph Ga	ash		
8760,	Cate be executed by sician and busician and busician and the purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	PNEUM	ILURE				
.O. Box 68	ne death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	h			Date of delive	ery Day Year
Δ.	requires that the bear signed by should be detact	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause give	on in Part I.		obacco use co Yes 2 □ No		he cause of death?
Il Records,		Completed						24a. Was autor perio 1 ☐ Yes		b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
Vital	Physician: The this certificate har director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 NInpatient 2 -	ER/Outpatier	nt 3 DOA Othe	26. Place of Dea	th (Check only o		Other (Specia	6)
ion of	ing Ph a. After th funeral	atlon: T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	at	28d. Describe I			,,
Division	or At offer of Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	v)			City or Tov	wn, State)		al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examinone)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and plac	manner as s e, and due t	stated. the cause(s)
>	To th To th	Me	29b. Signature and title of certifier • Mellyw	lemuy M	D	29c. License	79 /		29d. Date sign	ned (Month,	Day, Year)
(in the later)	Ψ.		MVENURY 98		A	Print) HVE,	SILVER	SPA	ZING	- M	0 20902
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 4 2004	32 Registrar's Signa	ture	Sparker					

ABRESON, Philip 8/11/04 1608

			1 - For Amend Item 24		yland / Dep o.,G834 ₆ 0	artment	of Health +dhbeat	and M) () ()	25381
П	Physici	an	1. Decedent's Name (First, Middle, Last, Frank Michael A						2. Date of Dea Month	Day	2004	1735 M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, To	own, or Locatio	n of Death	July	2Z 4c. Co	unty of Death	. 730
	Exami	er	Washington Count			Нас	erstow	n		Wa	shinata	on County
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birthday,	If Under 1	Year If Und	er 24 Hrs.	8. Date of Birt (Month, Day	h		ace (State or Foreign
	Director		216-78-7407	M 2□F	44 Yrs.		,		May 13		New '	
	land		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or L	ocation					10	Od. Inside City Limits
	Mary -f sho	tor	Maryland Washingt	on	Boonsbo	ro						1 ☐ Yes 2 ☐ No
	or 28a	Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen	of What Coun	try?
	23a c		8913 Lums Lane			217					S.A.	
	tems	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Deceder If Yes, specify	nt of Hispanic (y Cuban, Mexic	Origin? (Spe can, Puerto	cify Yes or No- Rican, etc.)	14.	Race - America Black, White, e	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1□ Yes 2	□No <i>Speci</i>	ty:		Sp	ec <i>ity:</i> Whit	te
21215-0036	within 72 hours after death with the Maryland iene. iene. rthen "naturel", or liems 23e or 28e-f show then Redicel Examinat must be Inditited at the Medicel Examinat must be Inditited at	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual (Occupation			16b. Kind	of Business/Ind	lustry
215	within 7, ene. then "n	pie	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life.	DO NOT use	done during m retired)	OST OF WORK	ng			
		Completed		4	Res	ervati					line	
and	ed la la la la la la la la la la la la la	Be	17. Father's Name (First, Middle, Last)				18. Mo	tners Name	(First, Middle,	Maiden Sui	пате)	
Maryland	d 2 should by th and Menta 7 Is marked treumetic e	2	Felice Carlos Ant		19b. Mail	ing Address (5			e Tambo		wn. State. Zip	Code) 33880
Ma	12 s h ar 7 ls reu		Christine Antonio						mit 282			
ē,	es 1 and of Healti f item 2 r other 1		20a. Method of Disposition		20b. Place of Disp cemetery, cre	osition (Name	of er place)		ate	20c. Locati	on - City or To	wn, State
Ë			1 ☐ Burial 2 XXX remation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)					July	23, 04	Smith	sburg,	Maryland
Baltimore,	permit. Pag Department Importent: I any injury c		21. Signature of Funeral Service Licens	88	7 2	2. Name and	Address of Fac	cility Dou	ıglas A.	. Fier	y Funer	ral Home
THE INTERIOR	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	consequence of):	ter the mode	of dying, such	as cardiac d	or respiratory ar	rest,		rland 21742 Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	edicai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):		· drdi	ueny	<i>۳</i> ۲۲	A.O.W.		
O. Box	at the death certific by the attending pi tached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal death 3	□Ectopic preg □ Other (spec				23d	Date of delive Month	ry Day Year
rds, P.	quires that n signed by	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying cau	use given in Pa	rt I.	23e. Did to			e cause of death? ably 4 □Unknown
Il Records,		Completed						···			prior to con death?	osy findings available inpletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other _		(Check only o			
of	Phys this ral dii	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	28b. Time		c. Injury at Work?		me 5 Residence R			')
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, s (Specify)	treet, factory,	office		28f. Location (S City or Tox	Street and N vn, State)	umber or Rural	Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dis completely filled in	Medical		rsician: To the best of iner: On the basis of e and manner state	my knowledge, dea examination and/or in ed.	th occurred at nvestigation, in	the time, date n my opinion, d	and place, death occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)
•	To t To t	M	29b. Signature and title of certifier	reder	· · · · · · · · · · · · · · · · · · ·	29c.	License numbe	396		29d. Date si	23 0	ared. the cause(s) Day, Year) Ary and
				rorsh	ath (Item 23a) (Type	26 C	Igal (Court	- Hag	ersto	wn M	ary land
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	Signature	ports	1		,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Rag. No I. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2004 **Physician** James Alvin Barker, Jr. July 23, 5:00P M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Hospice House Linthicum Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**∑**M 2□F Months Director 236-22-7287 82 Mar. 8, 1922 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or itams 23a or 28a-f show treumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1975 Valley Road 21401 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W.W.II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Substation Manager Electric Utility s 1 and 2 should be fil f Health and Mental H itam 27 is marked ott 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 James Alvin Barker Nora Lilly Barker Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 i Daughter Linda Lou Walker / 1975 Valley Rd., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 7/27/04 rtment Blue Ridge Memorial Gardens Beckley, WV permit.
Departn
Importe
any injt 21. Signature o Funeral Service Licensee 22. Name and Address of Facility Tyree Funeral Home unnie 999 Jones Ave., Oak Hill, WV 25901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Colorectal disease or condition resulting in death) 14 months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 2 No 3 Probably 4 Unknown 1 🗆 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 1 Yes 2 XNo 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) H 5 Spice 1 ☐ Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t Certification: 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation Diractor: 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within To tha 29c. License number 29d. Date signed (Month, Day, Year) apine weiner, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Werner, MD 900 Bestgate Road #300, Annapolis, MD 21401

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

27

32. Pegistrar's Signature

			For State Registrar		State of I	Maryland	-	artment (<i>rtificate</i>			d Mental	Hygie Reg.		05000
			1. Decedent's Name	(First, Middle, L.	ast)							of Death	2004	3. Time of Death
	Physici /Medic		Steven	Beck							Jul		Day Yes	5:25 PMM
	Examin		4a. Facility Name (If r	_				4b. City, To		ocation of D			4c. County of D	
					entist Ho					kville			Montg	
	Funeral Director		5. Social Security Nur 220–60–21		Sex 7. 1 🕱 M 2 🗆 F	Age (In yrs. last	t birthday) Yrs.	If Under 1	Year Days	Hours N	Vin. (Mon	of Birth th, Day, Ye • 17,	ar) 9.1	Birthplace (State or Foreign Country) New York
			Usual Residence of D								Тобро	,		
	show	_		10b. County		10c. City, T	fown or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Be-f	ecto		Montgom	ery			Germa		wn		10-	Citizen of What	
	N with t	ai Dir	10e. Street and Numb					10f. Zip C	208	74			ited St	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I Health and Mental Hygiene. I team 27 is marked other then "natural", or items 23a or 28e-f show other treumatic event, the Medical Evaninal must be indiffical at	Funeral Director	11. Marital Status	d 2 🕅 Married	12. Was Decede Armed Force 1 \(\text{Yes} \) 2	es?				panic Origin Mexican, P	? (Specify Yes uerto Rican, et	or No- c.)		merican Indian, /hite, etc.
21215-0036	hours a	by	3 Widowed 4	Divorced	If Yes, Give Year or Date	es:		1 □ Yes 200 dent's Usual 0		Specify:		106	Specify:	White
-51	n "nat	Completed	(Specify	, , ,	rade completed)		(Give	kind of work DO NOT use	done du retired)	ring most of	working	100	. Kind of Busine	ss/moustry
212	filed within Hygiene. other then "	mo	Elementary/Second	dary (0-12)	College (1-4	Or 5+)	Cont	ract S						t/Flooring
and	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental Bernell and the Mental Bernell and	To Be (17. Father's Name (F Emmitt T		_				1		Name (First, A		den Surname) Kohnmun	ch
Maryland	12 should h and Men 7 Is marke treumatic		19a. Informant's Nan Marie Jean					-					ty or Town, State	e, <i>Zip Code)</i> MD 20874
	of Health item 27 I	1	20a. Method of Dispo					sition (Name natory or othe		1	Date		. Location - City	
MO M	Pages nent of i		1 🗆 Burial 2 🔀		□Removal from State ify)			itan Cı		tory	Ju1y 24 2004	A	lexandr:	ia, Virginia
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Fundamental RA	eral Service Line	From		22 I	Name and Park Di	Address rive	of Facility [, Gait	DeVol F thersbu	unera rg, M	1 Home D 20877	10 East Deen
			23a. Part1. Enter the shock, or heart	disease, or confailure. List onl	mplications that cau	ised the death.	Do not ent	er the mode of	of dying,	such as car	rdiac or respira	tory arrest,		Approximate Interval Between
	Priysician	s a	Immediate Cause (F	inal	. Uppe	gaste	ounte	estima	1	bleed	leng			Onset and Death HCULS
	/Medical Examiner		resulting in death)		Due to (or	as consequer	nce of):	Da (.e).	in	+ 0	corka	Gir		weeks
	- 13	Jer	Sequentially list cond if any, leading to imm	ditions, nediate	b. Due to	as a consequer	nce of):	03/0-	1/1		0000	TVJ		
	icate be executed physician and the burial-transit	Examiner	cause. Enter Underly Cause (Disease or in that initiated events		c									
50,	cate be execu physician and the burial-tra	EX	resulting in death) La	ast	Due to (or	as a consequer	nce of):							
58760,	physic the b	edical		•	d									
-			IF FEMALE:		23c. If yes, outco	me of pregnance	у						23d. Date of	delivery
O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 m 1 Yes 2 U 9 Unknown	nonths?	=	h 2 ☐ Fetal de nt at time of deat m		Ectopic preg Other (spec					Month	Day Year
, P.O	res that the de signed by the a l be detached f	y Ph	Part II. Other signific	cant conditions	contributing to deal	th but not resulting	ng in the u	nderlying cau	se given	in Part I.	23e.	Did tobacc	co use contribute	e to the cause of death?
Records,	w requires been sign should be	ed by	COPD								_	1 Yes	2 No 3	Probably 4 🗀 Unknown
eco	law re as bee 2 sho	Completed									24a.	Was an autopsy	prior	autopsy findings available to completion of cause of
Ä	ician: The lav certificate has rector, page 2	Com									10	performed	? death	1?
Vital	cian: ertific ector,	Be (25. Was case referre	ed to medical	Magnital A					26. Place of	Death (Check	only one)		
of	this aldi	-T	1 Yes 2 XIN	10	Hospital: 1 Inp		VOutpatier		Other				6 Other (S	Specify)
o	ding F h. After funer	tion	1 Natural 2 Accident	5 Pending investigati	28a. Date of (Month,	Day Year)	Injury	м	i. Injury a Work? 1 ☐ Ye	n' es 2 ∐ No	200. 200	01100 11000 11	ijary coodii od	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director; Afte completely filled in by the fune	Certification:	3 Suicide 4 Homicide	6 Could not determine	be 28e. Place of	f Injury - At home , etc. (Specify)	e, farm, sti	eet, factory, o	office			tion (Street or Town, St		Rural Route Number,
	pitel o		29a. Certifier	Certifying F	Physicien: To the b	est of my knowle	edge deat	h occurred at	the time	date and p	lace, and due t	o the cause	e(s) and manner	as stated
	To the Hospitel within 24 hours a To the Funeral to completely filled	Medical	(Check only 2 one)		miner: On the bas and manne	is of examination								
	To the To the Comp	Ž	29b. Signature and to	inte of certifier		0	1.1	29c. L	icense	number		29d.	Date signed (Mo	onth, Day, Year)
	20		140	era V	Collin	war	- 14	りし	-7'	177		Ju	My 13	2004
			30. Name and address					Print)	RA	Di	CKUILL	E A	10 10	200
	Sta	ate.	AAN S- 31. Date filed (Month	n, Day, Year)		gistrar's Signatur	-	3100/2	4)	100	NO ICL	2 /	1) 00	040
	Regist				004	una	9	Span	Ks	1				

DHMH 17 Rev 1/2001

			1 - State of Maryland / De State of Maryland / De Registrar	partment of Health and Mertificate of Death	fental Hygie		25384
	Physic	d an	Decedent's Name (First, Middle, Last)		2. Date of Death	2	3. Time of Death
	/Medi		CHARLES ALVIN BLACK		July	25 2004	7:46 PM
1	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
			4000 Highview Drive	Silver Spring		Montgom	erv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth		thplace (State or Foreign
	Director		247.42.0508 1MM 2 F 73 Yrs.	Months Days Hours Min.	Month, Day, Y May 12,	1931 Gaf	fney, S.C.
	pur		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or				
	aryla	2	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Ba-f	Sct	Maryland Montgomery Silver	Spring			1 X Yes 2 □ No
	with t	Di	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
	ath v	ra	4000 Highview Drive	20906		U.S.A.	
	er de Itam	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces? Korean	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	s aft	by F	If Yes, Give	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 ahow alsal Examinar must be multiped at	D D	- 13.3.3.3.3.				
1 5	n 72 "na"	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working		b. Kind of Business/	
12	with ene. thar	Ĕ	College (1-4or 5+)	DO NOT use retired)		NAVSEA	of the Navy
9	filed Hygi othar		17. Father's Name (First, Middle, Last)	puty Director	(First, Middle, Mai		
an	d be antal) Be	Isaac Lawson Black		• Simmons	den Surname)	
\leq	mark mati	ပ္					
Maryland	d 2 s th ar trau			ing Address (Street and Number or Rura			
Ġ	1 an Heal am 3	11.3		O Highview Drive, S			
ē	ages in tot		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)		. Location - City or	
Baltimore,	rtant njury		'4 □Donation 5 □Other (Specify) Parklawn	Memorial Park 07/3	30/04 Ro	ckville,	Maryland
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amortant: If item 27 is marked other than "natural", or items 23a or 28a-f ahow amortant: Item in the Madical Exercities for items to an amortant in an amore.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility INES-RINALDI FUNERA 1800 New Hampshire	AL HOME.	TNC.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	1800 New Hampshire	Ave, Sil	ver Sprin	g, MD 20904
			shock, or heart failure. List only one cause on each line.	nor the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
}	Physician /Medical		resulting in death) resulting in death)	ema			Criset and Death
	Examiner		Due to (or as a consequence of):				
ш		e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	red	Examiner	cause. Enter Underlying				
	al-tra	хаг	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	cate be executed hysician and the burial-transit	a					
68/	death certificate be executed e attending physician and id for use as the burial-transit	edical	d				
×	leath certific attending p	× ×	IF FEMALE: 23b. Was decedent pregnant. 23c. If yes, outcome of pregnancy				
Вох	atter for L	ciar	in the past 12 months?	Ectopic pregnancy		23d. Date of delive	/ery Day Year
o.	at the de by the a	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 [9 ☐ Unknown 9 ☐ Unknown	Other (specify)			,
ج آ	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the t	Inderlying cause given in Part I	23e Did tobaco	o use contribute to	the cause of death?
ds	uires I sigr Id be	Ω	Coronary Atherosclerosis	, , , , , , , , , , , , , , , , , , , ,			bably 4 Unknown
õ	w requir been si should b	ete	Substernal Thyroid/Goiter		-		
Hecords,	sician: The law certificate has birector, page 2 s	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
_	n: The		Anemia		performed 1 Yes 2 ₹		2 No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
O	al d	10	1 Inpatient 2 ER/Outpaties	The state of the s	e 5 🔀 Residence	6 ☐ Other (Special	fy)
_	D 0 0	5	1 XNatural 5 ☐ Pending (Month, Day Year) Injury	Work?	8d. Describe how in	jury occurred	
S	Attanding ir death. actor: After by the fune	Cal	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
=	al or Attandin s after death. Il Diractor: Aft id in by the fur	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, st. building, etc. (Specify)	eet, factory, office	Bf. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,
_	pita oral	OL	29a. Certifier 1X Certifying Physician: To the best of my knowledge deat				
	To the Hospital of within 24 hours a To the Funeral Completely filled in	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in	n occurred at the time, date and place, ar vestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as s and place, and due to	tated. o the cause(s)
	o the ithin o tha		29b. Signature and title of certifier	29c. License number			
			DIA. Y			Date signed (Month,	
	10	-	- gontry were	D-35045	Ju	ly 29, 20	04
			30. Name and address of person who completed cause of death (Item 23a) (Type,		_		
	CAN	0	Philip G. Henjum, M.D., 3416 Olando 31. Date filed (Month, Day, Year) 32. Régistrar's Signature		lney, Mar	yland 208	332
	Stat Registra		JUL 3 0 2004	Sparkel			

			1 - For State Registrar	State of M	arylan		artment rtificate					Reg. No.	State of the latest of the lat	253	85
	Physici		1. Decedent's Name (First, Middle, Last) Fannie N. Bois	vert						,	2. Date of De Month July	2 Day	2004	3. Time of 9:30	Death A M
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number))		4b. City,	Town, or	Location of	of Death		4c. Co	unty of Death		
1	LXdiiii		18504 Cape Jasmin	e Way				Gait	hers	burg		Мот	ntgomer	У	
	Funeral	1	Social Security Number 6. Sex		ge (In yrs. I	ast birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir	th v. Year)	9. Birthp	lace (State o	r Foreign
ш	Director		578 – 38 – 1725	M 2 X]F	89	Yrs.	INDITIO	Days	Tiodis		Jan. 7,	1915	New	York	
	p .		Usual Residence of Decedent 10a. State 10b. County		10c Cib	r. Town or Lo	cation							0d. Inside Ci	ity Limite
	ehov	<u> </u>			Too. Oity								Ι.	1 X Yes	•
	8e-1	ecto	MD Anne Aru	ndel			asade					10- 0::	-614/5-1-0		
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28e-f ehow the Medical Examation count by collinat at	ä	10e. Street and Number				10f. Zip	Code	21122	2			of What Cour ed Stat	-	
	e 23	rai	324 Shady Lane	12. Was Decedent	Ever in III	C 12	Mas Doord	ont of Hi			noify Voc or No		Race - Americ		
	item item	- n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Amed Forces	?	42-	If Yes, spec	ify Cubai	n, Mexican	i, Puerto	ecify Yes or No Rican, etc.)	, ,,,	Black, White,		
36	rs aff	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	19	42 - 45	1 ☐ Yes 2	No X	Specify:			Sp	ecify: Wh	ite	
21215-0036	2 hou	ed	15. Decedent's Edu	cation			dent's Usua					16b. Kind d	of Business/Inc	dustry	
15	in 72	piet	(Specify only highest grade		5.\	(Give	kind of wor DO NOT us	k doné d e retired,	uring mosi I	t of worki	ng			1	
212	r the	E	Elementary/Secondary (0-12)	College (1-4or	3+)	Sec	retar	У				Print	ing In	dustri	les
b	othe	e C	17. Father's Name (First, Middle, Last)			-			18. Mothe	r's Name	(First, Middle	, Maiden Sui	name)		
a	Ald be Alenta rked tic ev	<u>B</u>	Ralph Nahmod						Ame:	lia	Salah				
Maryland	shot and A e me		19a. Informant's Name/Relationship (Ty	oe, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	il Route Numb	er, City or To	wn, State, Zip	Code)	
Σ	alth alth 27 i		Ernest R. Boisvert	/ Son		1850	4 Cap	e Ja	smine	e Way	y, Gait	hersbu	rg, MD	20879)
ore	item item		20a. Method of Disposition	amaual from State	06	lace of Dispo	sition (Nam	ne of ther place)		st 11	20c. Locati	on - City or To	wn, State	
Ĕ	Page Ting		1 🌠 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State		ington	Nati	ona1		Augu 20	84 11	Arlin	gton ,	VA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importents: if item 27 is marked other then "natural", or iteme 23a or 28e-1 show among your or other treumatic event, the Medical Examinational be notified at once.		21. Signature of Funeral Service License			De	Name and er Pa	d Addres	s of Facilit	y Dev Ga	Vol Fun Lthersb	eral H urg, M	lome, 1 D 2087	0 East 7	:
			23a. Part1. Enter the disease, or compli	cations that cause	d the death	. Do not ent	er the mode	e of dying	, such as	cardiac c	r respiratory a	rrest,		Approximate	
	Physician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each i			1	A	. 1					Onset and D	
7	/Medical		disease or condition resulting in death)	Due to (or as		brovas Jence of):	cular	Acc	ıaenı	E					
	Examiner														
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	uence of):									
	uted d ansit	Examine	Cause (Disease or injury that initiated events												
o,	exection and and rial-tr	Ex	resulting in death) Last	Due to (or as	a consequ	uence of):									
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dicai		l											
9	tiffica ng ph as th	led													
Вох	death certifica attending ph of for use as the	Physician/Med	23b. was decedent pregnant	3c. If yes, outcome 1 Live birth			Ectopic pre	ennancy				23d.	Date of delive	,	
	deat	lcie	in the past 12 months? 1 Yes 2 No	4☐Pregnant a			Other (spe		_				Month	Day Y	'ear
P.0	by the	hys	9 Unknown												
	res that the de igned by the a be detached	by F	Part II. Other significant conditions cor	tributing to death b	out not resu	ulting in the u	nderlying ca	ause give	n in Part I.				contribute to th		
ord	v require been si should I										10	Yes 2 N	o 3 ☐ Prob	ably 4. X]U	nknown
Records,	law requas been 2 shoul	Completed									24a. Was	DSV	b. Were autop	sy findings a	ivailable ause of
Ä	о <u>г</u> е	E O									perfo 1 ☐ Yes	rmed? 2X No	death? 1 ☐ Yes		
Vital	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o				
_ _	d is	To	1 ☐ Yes 2 X No	ospital: 1 Inpati	ent 2 🗆 l	ER/Outpatier	nt 3□ DO	A Othe	r. 4□Nu	rsing Hor	ne 5 🗆 Resid	dence 6 🛚	So Other <i>(Specif</i> y	ns Home	
n of	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ny Year)	28b. Time of Injury	f 21	Bc. Injury Work	at ?	- 2	28d. Describe I	how injury oc	curred		
Ö	Attending in death.	atle	2 Accident investigation				М	1 🗆 Y	es 2 🗆 1	No					
Division		Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et			eet, factory	, office		4	28f. Location (3 City or Tox		imber or Rura	Route Numb	ter,
Q	spitel or ours atto nerel Dia filled in	Cer													
	Hos Fur ely	edical	29a. Certifier 11 Certifying Phys (Check only 2 Medical Examin	er: On the basis of	of examinat										
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	and manner st	ated.		29c	License	number			29d. Date sid	ned (Month, I	Dav. Year)	
		-		ap uss				D397					22, 200		
1	0		. 0,200			00-1-7							,	•	
			30. Name and address of person who co					1.4	D ==	مال	07 01	nor- 35	ת מממים	,	
	0.		Christopher J. May 31. Date filed (Month, Day, Year)	32. Registi	rar's Signat					• * # 2	.U/, UL1	ney, M	D ZU832		
	Sta Regístr		JUL 28 200	14 Arms	العمر	19	ppo	uks							

DHMH 17 Rev 1/2001

Registrar

Endrance.

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2004

			1 - For State Registra/AMEND#23a(C)perN	State of Marylan		artment of H		nd Men			month of the second	25387
Ī	Physici		1. Decedent's Name (First, Middle, Last) Weir Brown					_ ^	ate of Death Month	Day 2004	Year	3. Time of Death 9:30
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, or	Location of		<i></i>	4c. County	of Death	7.30
			Brighton Gardens			Bethesd					tgom	ery
	Funeral Director		5/9.32.0204	7. Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. Ja	ate of Birth Month, Day, 1 n • 27 • 1	^(ear)	9. Birthp <i>Cour</i> I 1 1 1 1	place (State or Foreign htry) nois
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Manyl sho	ō	MD Montgome	ry	Bethe	sda						1 ☐ Yes 2000No
	28a	rec	10e. Street and Number			10f. Zip Code			10	g. Citizen of W	hat Cour	ntry?
	h with	Q E	5550 Tuckerman Lan	.e		20852				U.:	S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event. If a Medical Ever if art initial to rectified at once.	by Funeral Director	11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1XXyes 2 □ No If Yes, Give Year or Dates:WWII		Vas Decedent of Hi Yes, specify Cuba	spanic Origi n, Mexican, Specify:	in? (Specify Puerto Ricar	Yes or No- 1, etc.)		k, White,	ean Indian, etc. ite
Maryland 21215-0036	ithin 72 hou ne. nan "nature Medical E	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life. L	ent's Usual Occupa kind of work done o OO NOT use retired,	furing most of	of working	10	Sb. Kind of Bu		
7	led w lygier har th	Co	47 Sahada Nasa (Sisa Middle Leet)	5+	Eco	nomist	10 Mathar	a Nama /Fire	at Middle M	U.S.		ernment
yland	buld be fil Mental H arked ott	To Be	17. Father's Name (First, Middle, Last) Spencer Gilso				1	Nellie	Messi	ck		
, Mar	and 2 shoalth and 27 is mar traum		19a. Informant's Name/Relationship (Type Peter Brown/ Son	e, Print)		g Address <i>(Street a</i> rris Lane					State, Zip	(Code)
Baltimore,	ages 1.6 ent of He		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State	emetery, cren	sition (Name of natory or other place ort Crema		Date 7/19/0		oc. Location - exandr	•	
Baltii	permit. I Departm Importar any injui		21. Signature of Funeral Service License		22	Name and Addres Wiscon	s of Facility	Josep	h Gawl			
	Physician /Medical		23a. Part 1 Enfer the disease, or complic shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Respirator	y Fail		g, such as ca	ardiac or res	piratory arres	t,		Approximate Interval Between Onset and Death
	Examiner	L ,		Due to (or as a conseq Bilateral	Pneumo							
	scuted and transit	amine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Aspiration		onia						
8760,	cate be executed oblysician and the burial-transit	dical Examiner	d.	Severe Dys								
O. Box 6	ne death certifi the attending pheed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Bc. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of d	I death 3	Ectopic pregnancy Other (specify)				23d. Date Mon		ery Day Year
٥.	quires that the signed by all be detacted	by	Part II. Other significant conditions conf	tributing to death but not res	ulting in the ur	iderlying cause give	en in Part I.		23e. Did toba 1 ☐ Yes	v		ne cause of death? ably 4 Unknown
Il Records,		Completed							24a. Was an autopsy performs	0	/ere auto rior to cor eath? Yes	psy findings available mpletion of cause of 2 No
Viital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	a a nital		Othe			eck only one)		_	
of	d is	2	1 Yes A No		ER/Outpatient 28b. Time of		4 KZ NUIS			ce 6 Othe		y)
Division of	Attanding Physician: sr death. ector: After this certific. by the funeral director.	Certification:	27. Manner of Death 1XX statural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	rat ⟨? Yes 2 □ No	0				
Σ	a Hospital or Attant 24 hours after death a Funaral Director: etely filled in by the	Certifi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre	eet, factory, office			ocation (Stre City or Town,		r or Hura	l Route Number,
	To the Hospitel or Attending Phwitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical		ician: To the best of my kno er: On the basis of examina and manner stated.								
	To the To the Comp	Σ	29b. Signature and title of certifier	1/2		29c. License	_			I. Date signed		
)	12		Merlyn	/ lein	UGI,	D3579	1		Jυ	11y 16,	200	4
	1 -		30. Name and address of person who cor Merlyn Veacury, M.		4	venue Sui	te 22	7 Silv	er Spr	ing, M	D 2	0902
	Sta Registr	_	31. Date filed (Month, Day, Year) JUL 26 200	32. Registrar's Signa		Sporth						

Physici		Registrar # 23a,27 1. Decedent's Name (First, Middle,		ME,8/23/04	rti <u>fic</u> ate	of Death		Reg. No. 0 0	4 2538
		ANTHONY	E. BENS	SON			2. Date of De. Month JULY		3. Time of De
/Medic Examin		4a. Facility Name (If not institution,			4b. City, To	own, or Location of D		4c. County of	
		PRINCE GEORGES			CHEVE			PRINCE (GEORGES
Funeral Director		5. Social Security Number 219-17-2075 Usual Residence of Decedent	6. Sex 7. X □ M 2□ F	Age (In yrs. last birthday 17 Yrs.				y Year) 0,1986	Birthplace (State or F Country) Maryland
MON II		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City L
e-f sh Liffied	ctor	DC No	one	Washi	ngton				1 ∑ Yes 2
or 28	Dire	10e. Street and Number		#808A	10f. Zip Co			10g. Citizen of Wha	at Country?
ns 236	Funeral Director	4660 Marin L	12. Was Decede			20032	2 (Coostu Vas es Na	U.S.	American Indian,
Department of Health and Mental Hygiene. Importent: If item 27s or 28e-f show importent: If item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at DRG.	à	1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force	s? ∐No	If Yes, specify		? (Specify Yes or No- uerto Rican, etc.)		White, etc. Black
natur	Completed	15. Decedent's (Specify only highest	Education	16a. Dece	edent's Usual (Occupation	working	16b. Kind of Busin	ness/Industry
than "	mpl	Elementary/Secondary (0-12)	College (1-4d	or 5+)		done during most of retired)	Working	Shopper	
Hygie othar ent, tt	ပိ	11th 17. Father's Name (First, Middle, L	ast)		Cashi		Name (First, Middle,	Grocery Maiden Sumame)	Store
fic ever	To Be	Michael Boy	wens				verlyn E	,	
and N Is ma	-	19a. Informant's Name/Relationshi	p (Type, Print)	19b. Mail	ing Address (S	Street and Number or	Rural Route Numbe	TO A S TOWN, Sta	ite Zip Code) Iton, DC 2
fealth im 27 har tr		Javerlyn Be	enson (Mo	ther) 466	U Mar.	in Luthe	er King A	Ave, SW	#308
or of the state of		20a. Method of Disposition Burial 2 ☐ Cremation :		Les .	matory or other	r place)	Date	20c. Location - Cit	
artme ortent injury	1	'4 Departion 5 ☐ Other (Special Service ☐	Z-1 11	Glenwoo			3/04 SNOWDEN		ton, DC HOME, P
Depa Impo any ir once.		Gerry 1	AMA	wklu					MD 2085
# #	Examiner	Sequentially list conditions, if any, leading to immediate	Due to (or						i i
rsician and 9 burial-trans	cai Exa	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):					
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		1	For State Registrar	State of Mar		artment of H		Re	g. NØ.		25389
	Physicia	an	Decedent's Name (First, Middle, Las DONALD CECIL	BLACK				2. Date of Deat Month August		0 ^{Year}	3. Time of Death 12:05 A M
	- /Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	1	4c. County	of Death	
	LXamin	٠.	Shady Grove Adve	ntist Hospi	ta1	Rockvil:	le		Montg		
1	Funeral Director		3//-12-3661	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept. 28	3,1920	9. Birthp Cour Mich	lace (State or Foreign itry) iigan
	/iand	-	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation				1	0d. Inside City Limits
	Ba-f st	Director	Md. Montgome	ry	Montgomer	ry Village	е	1	0g. Citizen of V	What Cour	1 ☐ Yes 2 No
	a or 2	급	19706 Greenside T	orrace		208	86		Inited		-
	ns 23	era	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of H		pecify Yes or No-			an Indian,
200	urs after d ai', or Iten Evandoer	by Fun	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	1950-	n Yes, specify Cuba 1 ☐ Yes 2 🂢 No	Specify:	o Rican, etc.)		ck, White, v: Whi	
Baitimore, Maryland 21219-0030	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic evant, its Madicul Evanther must be notified a page. Once.	Completed by Funeral	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of woi f)	rking	United Air Fo	Stat	•
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Mary	12 should he and Me	2	19a. Informant's Name/Relationship (_		ng Address (Street 5 Aspenwo					
Je, I	of Health of Health fitam 27		Bruce D. Black (20a. Method of Disposition 1 Burial 2 M Cremation 3	Son)	20b. Place of Dispercemetery, cre		1	Date	20c. Location	City or To	own, State
Ĕ	artment printing		*4 □Donation 5 □Other (Specification 21. Signature of Funeyal Service Licer	y)		itan Crem 2. Name and Addre	• 20	04	Alexand		Va.
n	Dep Imp any		Custin E. K	den	11	D East De	er Park	Dr. Gaith	nersbur	g, Mo	1. 20877
B	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused the one cau is on each line	he death. Do not en		ng, such as cardia	c or respiratory arr	est,	1	Approximate Interval Between Onset and Death
	/Medical.	cal Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):	محمحص	Arser) Disco	&:		Years_
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Vita		Be C	25. Was case referred to medical examiner?					ath (Check only of	ne)		
ot <	Physician: this certific ral director,	2	1 ☐ Yes 2 😾 No	Hospital: 1X Inpatien		ant 3 DOA		Home 5 Resid			fy)
	Jing After fune	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) 28b. Time Injury	Wo	ry at rk?]Yes 2 ☐No				
Division	s after deatl	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	building, etc.				City or Tow	m, State)		al Route Number,
	To the Hospital or Att within 24 hours after d To the Funaral Diract completely filled in by	Medical (29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of miner: On the basis of and manner stat	examination and/or i	ath occurred at the tinvestigation, in my	me, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place	anner as , and due	stated. to the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	2 2		Wy 29c. Licen	se number	/	29d. Date sign	ed (Month	. Day, Year)
)	15+1		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type		8072	<i>F</i>	lugust	3	2004
			Dr. Jonathan Wen				. Rockvi	11e, Md.	20850		
	St	ate	31. Date filed (Month, Day, Year)	32. Registra		Sour					

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			1 - For State Registrar	State of Maryla	•	artment of F			giene Reg. No?	25200
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last MAXINE V. 4a. Facility Name (If not institution, give	BUDI	D	4b. City, Town, o	r Location of De	2. Date of De. Month JULY		04 10:15 Bn
	Funeral Director		21/-30-06/2		gton s. last birthday) Yrs.	Ken If Under 1 Year Months Days	singto If Under 24 H Hours Mi	n. 8. Date of Birt	y, Year) (omery hirthplace (State or Foreign Country) aryland
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any jury or other traumatic event, If a Madical Examinational Examination once.	al Director	Usual Residence of Decedent	mery	Silv	er Spri			10g. Citizen of What (10d. Inside City Limits 1 □ ¥es 2 □ No Country?
-0036	hours after deal stural, or Items	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 Yes 2 1 No	Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wr Specify:	Black
nd 21215	e filed within 72 al Hygiene. I other than "na vent, ILe Medic	Be Completed	(Specify only highest grad Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	kind of work done DO NOT use retired d Servi	during most of w d) ce Wor	,	Montgon Public S	nery Co
, Maryla	and 2 should beath and Ments and Ments and Ments n 27 is marked for traumatic e	Tof	Kenneth Do 19a. Informant's Name/Relationship (T) Pearl Moore- S		19b. Mailir 154	ng Address (Street	and Number or	ary P Bi Rural Route Numbe e Rd Si		Zip Code) 20905 Lng, MD
Baltimore, Maryland 21215-0036	permit. Pages 1: Department of He Important: If item any injury or oth		20a. Method of Disposition 1 Daurial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice	Removal from State	cemetery, crer A.s.h Me: 22	. Name and Addres	8/ ss of Facility	Snowden		oring, MD Home P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease for complete shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	ications that caused the de- ne cause on each line. Brain Due to (or as a conse	Ade	er the mode of dyin		ac or respiratory ar	rest,	Approximate Interval Between Onset and Death Tyears
38760,	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ixsease or injury that initiated events resulting in death) Last	Due to (or as a consect. Due to (or as a consect.						
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Division of Vital	ittending death. ctor: Afte y the fune	Certification; To	27. Manner of Death 1 X Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At I	28b. Time of Injury	28c. Injury Work	at	28d. Describe h	ence 6 Other (Specow injury occurred	
D	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	Medical Certi	4 Homicide determined 29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	building, etc. (Special Specia	oify)	occurred at the tim	ne, date and place	City or Tow	n, State)	s stated.
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	Sta	te	30. Name and address of person who co Aphina Heuhui, 31. Date filed (Month, Day, Year)	MD 2309 SI 32 Registrar's Sign	horefi	eld Rd		n, MD 20	0902	
	Registr		ALIG 0 6 2004		B	Sparks	*			

			1 - For State Registrar	State o	of Maryland /		artment rtificate				lental Hy	ygien Reg. N	2001	25301	
			Decedent's Name (First, Middle, Last)								2. Date of D		0. U U 19	3. Time of Death	
	Physic		Robert Bruce		Month July						Year 2004				
	/Medi Exami		4a. Facility Name (If not institution	4b. City, To	own, or	Location of	of Death	July	24	County of Death	2:45A M				
			Montgomery Hos					kvi							
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	oirthday)	If Under 1	Year	If Under		8. Date of B	irth	Iontgomen	ry nplace (State or Foreign	
	Director		577-54-8444	1(X M 2□F	65	Yrs.	Months [Days	Hours	Min.	(Month, D	ay, Year,) Coi	th Carolina	
	P		Usual Residence of Decedent				1				riar CII	20,1	222 INOT L	n carolina	
	larylan show	_	10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits	
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	r dea	nei	11. Marital Status	12. Was Dece	edent Ever in U.S.	13.	Was Deceder			gin? (Spe	ecify Yes or No Rican, etc.)	o-	14. Race - Amer		
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anc	be fi	Be	17. Father's Name (First, Middle,						18. Mothe	r's Name	(First, Middle	, Maider	Sumame)		
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Maryland	permit. Pages 1 and 2 should b Department of Health and Menis Important: If Itam 27 is merked any injury or other traumatic e once.	1 8	19a. Informant's Name/Relations							r or Rura	l Route Numb	er, City	or Town, State, Zij	p Code)	
	1 and tealth	13	Claudette C. Ca	udell V			Geren		ad	Silv	er Spr		Maryland		
Ö	ges H of H		20a. Method of Disposition 1 □ Burial 2 ☆Cremation	3 Removal from	cemete	ery, cren	sition (Name natory or othe	r place)		ate		ocation - City or T		
Ë	tant:		'4 □Donation 5 □ Other (S	pecify)	Metro	poli	ltan Crema	ator	·v J	u1.2	4.2004	Alex	eandria '	Virginia	
Baltimore,	ermit lepar npor ny in		21. Signature of Funeral Service	Licen ee	0	22 F 7	Name and A	Address T	of Facility	inc	Funorol	l Hor	no To-	*********	
	σΩ <u>=</u> « α		Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring. MD 2090											MD 20901	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate interval Between												
	Physician	Ř h	Immediate Cause (Final disease or condition	Chron	nic Obstru	ctiv	<i>te</i> Pii1n	ກດກະ	rv D	isea	80			Onset and Death	
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Вох	death certifii e attending p id for use as	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	come of pregnancy irth 2 D Fetal death	n 3 🗆	Ectopic pregn	nancy				2	23d. Date of delive		
0	0 0	Sic	1 Yes 2 No	4☐Pregna 9☐Unkno	ant at time of death	5 🗆	Other (specif	(y)					Month	Day Year	
<u>G</u>	that the de led by the a detached f	Physician/Me													
Ś	es De	by	Part II. Other significant condition	ns contributing to de	eath but not resulting i	in the un	derlying caus	e given	in Part I.					he cause of death?	
0.0	w requir been s should	ted									101	res 2[□No 3□Prob	ably 4 ⊠Unknown	
Record	e law has b	Completed									24a. Was		24b. Were auto	psy findings available	
	The page	50									perfo	rmed? 2⊠ No	death?	impletion of cause of	
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?					- 2	26. Place o	of Death	(Check only o		1 1 1 6 3	2 140	
	diris	To	1 ☐ Yes 2 🔀 No	Hospital: t ☐ Ir	npatient 2 ☐ ER/Ou	utpatient	3□ DOA	Other:					S SOther (Specific	Hognica	
0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at						t		g Home 5 ☐ Residence 6 ☒Other (Specify) Hospice 28d. Describe how injury occurred				
<u>Ö</u>	Attending ir death. actor: After by the fune	atle	1 Matural 5 ☐ Pending 2 ☐ Accident investig	ation	,, ==, : 3=,	,ury		Work? 1 ☐ Ye	s 2 N	О					
Division of	or Attendate death Diractor: in by the	Certification:	3 Suicide 6 Could n	ned 288. Place	of Injury - At home, fa	arm, stre	et, factory, off	fice		21	8f. Location (S	Street and	d Number or Rura	l Route Number,	
	talor A rs after al Dira ed in by	Cer			g, otor (apoony)						City or Tow	m, State)			
	e Hospital 24 hours a a Funeral letely filled	cal	29a. Certifier 1 Certifying	Physician: To the	best of my knowledge	e, death	occurred at th	ne time,	date and	place, ar	nd due to the o	cause(s)	and manner as st	ated.	
	To the Hospital within 24 hours of To the Funeral completely filled	edical	one)	and mann	sis of examination an	na/or inve	estigation, in r	ny opin	non, death	occurre	d at the time, o	date and	place, and due to	the cause(s)	
	To the I	Σ	29b. Signature and little of certifle				29c. Lic	cense n	umber		2	29d. Date	signed (Month, L	Day, Year)	
,	0		CHAT			_	0	4	12	18		7	1241	04	
	ι -		30. Name and address of person v	no completed cause	of death (Item 23a)	(Туре, Р	rint)								
			Charles Harriso		6001 Muno	cast	er Mil	1 R	oad	Rock	ville.	Mar	vland 20	855	
	Stat		31. Date filed (Month, Day, Year)	32 Re	gistrar's Signature	,	Spark.								
	Registra	11:	1111 26 2	11114 And		Ji.	and a man								

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death										2	25392			
	Physici	an	Decedent's Name (First, Middle, Last)									eath 3. Time of Death					
	/Medi	cal	GENE A. CLARK					1 0° T				July	28,			$06:30 A^{M}$	
1	Examir	ier	4a. Facility Name (If not institution, give street and number) 1226 Benning Road Apartment 200					4b. City, Town, or Location of Death Capitol Heights					4c. County of Death Prince George's				
	Funeral Director		5. Social Security Number 244-52-926	8 6. Se	x Z M 2□F	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	3. Date of B (Month, D	irth ay, Year) 2-36		irthplac		
	and **		Usual Residence of Deceder 10a. State 10b. C			10c. City	. Town or Lo	cation							100	I. Inside City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or itame 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	tor	MD.	P.G.		С	apito	ol Hgt	ts.							1 XYes 2 □ No	
		Il Director	10e. Street and Number 1226 B	ennir	ing Road			10f. Zip Code 20743					10g. Citizen of What Country? U.S.A.				
5-0036		d by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Div	orced	12. Was Deced Armed Ford 1 Tyres 2 If Yes, Give Year or Da		1 ^{to}	Was Deceder f Yes, specification of Yes 2	y Cuban No	Specify:	in? (Spec Puerto R	ify Yes or N ican, etc.)	S	Black, Wh	ite, etc	·k	
21215-		Completed	(Specify onfy Elementary/Secondary (C			4or 5+)	(Give life. L	lent's Usual kind of work DO NOT use	done du retired)	uring most				of Business			
and 2		Be	17. Father's Name (First, M		Clar	k				18. Mother	's Name (First, Middle t Dul	, Maiden S			-	
Maryland		٦ 1	19a. Informant's Name/Reli Brenda C		1									Town, State,		20743	
re,		1	20a. Method of Disposition		····	20b. Pla	ace of Dispo	sition (Name	of	1	Da			ation - City o			
E			1 XBurial 2 ☐ Crema 1 Donation 5 ☐ Ott			tate	yland	-		′ I	8/3/	04	Chel	tenha	am.	Md.	
Baltimore,			21. Signare of Funeral Se	rvice Licens) ille	and	22	The I 814-	lou:	se of	f Wi		ns Fu	neral			
8760,	ricien: The law requires that the death certificate be executed certificate has been signed by the attending physician and injpic. rector, page 2 should be detached for use as the burial-transit	dical Examiner	shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(Due to (o	r as a consequent as a consequent	enca of):	rdio v	'as (cula	r d	isea				terval Between nset and Death	
P.O. Box 68		by Physiclan/Medl						□Ectopic pregnancy □ Other (specify)						23d. Date of delivery Month Day Year			
		ed by P	ed by PI	Part II. Other significant co	nditions cor	ntributing to dea	ith but not resul	ting in the un	iderlying cau	se giver	n in Part I.				contribute to		ause of death?
al Records,		Completed										15 Yes	psy rmed? 2 \(\subseteq No	24b. Were a prior to death? 1 X Yes	compl	findings available etion of cause of	
Vital	Physicien: this certificant	o Be	25. Was case referred to m examiner? [X] Yes 2 □ No	_	fospital:				Other			Check only			-	CODE	
of	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	\vdash	27. Manner of Death 1 Natural 5 P	ending vestigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			3 DOX 4 Nuising Hom				e 5 Residence XXOther (Specify) SCENE Bd. Describe how injury occurred					
Division		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)											(Street and Number or Rural Route Number, own, State)			
		Medical	29a. Certifier 1 Cer (Check only one) 2 Me	tifying Phys dical Exami	sician: To the b ner: On the bas and manne	is of examination	dedge, death on and/or inv	occurred at estigation, in	the time my opii	, date and nion, death	place, an	d due to the at the time,	cause(s) ar date and pl	nd manner as ace, and due	s state e to the	d. e cause(s)	
		Σ	29b. Signature and title of c					29c. l.	icense					signed (Mont			
	3		I hay I	١. ١	wi 5				0.0	C.M.E.	•		July	28, 2	.004		
			30. Name and address of pe	I. ih			23а) (Туре, Р 111 Ре	,	ceet	. Bal	timo	re, Ma	arylan	d 2120	01		
	Sta Registr		31. Date filed (Month, Day,	_	1 // -	gistrar's Signatu		Spar		-		•					

D			1 - Stata AMED#28foerMF1 Registrar AMED#100per.IN	State of Maryland / 8/6/04 EMW MCC 8/6/04, EMW, MCC		artment of H tificate of L			iene .g. n2 0 0 4	25393		
	- I.		1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	h Day Year	3. Time of Death		
	Physicia /Medic		George R. Cotner			July 2	3, Day 2004 Year	0245 P M				
	Examin		4a. Fecility Name (If not institution, give Prince George's H	4b. City, Town, or Cheverly	Location of Death		4c. County of Death Prince George's					
	Funeral Director		5. Social Security Number 6. Sec 231-64-4692 1X	7. Age (In yrs. last 53	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/12/	Year) 9. Bi	rthplace (State or Foreign Country)		
	pu 🔭		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits		
	Aaryli r sho	ō	MD Charles		an H					1 ☐ Yes 2\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	28a-	rect	10e. Street and Number	ocorge mur	all II	10f. Zip Code		1	0g. Citizen of What C	Country?		
	3e or	<u></u>	6575 Chicamuxen	Road		20640			USA			
	ems 2	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Spe In, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f show amportent: If item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinant be notified at anote.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ ②Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2¶ No	Specify:		·	aucasian		
5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa	during most of work	ing	16b. Kind of Busines	s/Industry		
2	hen "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		D 1111			
2	Hygie Hygie Ther t		12 17. Father's Name (First, Middle, Last)	2	car	penter	18. Mother's Name	e (First, Middle, M	Building Maiden Sumame)	2		
auc	d be f	o Be	Thomas E. Cotner				Jeanne					
Maryland	shoul nd Me mark mati	P P	19a. Informant's Name/Relationship (T)	rpa, Print) 1	9b. Mailir	ng Address (Street a	and Number or Run	al Route Number	; City or Town, State,	Zip Code)		
ž	alth a		Stephen Sean Rip	ley - Execu.	202	N. Cherr	y Street,	Falls_	Church, VA	22046		
ore,	of He of He ritem		20a. Method of Disposition 1 Burial 2XX Cremation 3 F			sition (Name of natory or other plac		Date . /200/	20c. Location - City of	r Town, State		
	Page ment ment of the page of		'4 □ Donation 5 □ Other (Specify)	Met	ropo	litan Cre	matory 22	1/2004	Alexandria	ı, VA		
	permit. Pag Department Importent: I any injury o		1 Burial 2XX remation 3 Removal from State 4 Donation 5 Other (Specify) 21. Storature of Funeral Service Lensee 22. Name and Address of Facility Advent Funeral Services, Lee Highway, Falls									
	cate be executed // Medical Examiner and the burial-transit		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between									
			Immediate Cause (Final disease or condition a									
			resulting in death) a Due to (or as a consequence of):									
18		Sequentially list conditions, b.										
		nine	Tary, is admig to immediate cause. Enter Underlying Cause (Disease or injury									
		Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequent								
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9		0										
Box	requires that the death certifit teen signed by the attending f hould be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death	ath 3[Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year		
P.0	t the by the tache	hys	9 🗆 Unknown	9□ Unknown				_				
Records, F	w requires that s been signed b should be deta	d by P	Part II. Other significant conditions co	ntributing to death but not resultin	g in the u	nderlying cause give	en in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown		
Ö	aw rec as beer 2 shou	Completed						24a. Was a		autopsy findings available		
Re	9 4	mo						autops perform				
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deat					
of V	Physicien: this certific ral director,	To	1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 🙀 ER/	Outpatier		4 Nursing no			6 ☐ Other (Specify)		
ū	ng Pt ifter th		27. Manner of Death 1 □Natural 5 □ Pending	(Month, Day Year)	b. Time o Injury	Worl	k?	Subject Shot Self				
Sio	tendi death. tor: A	icat	2 Accident investigation 3 Suicide 6 Could not be	7-23-07 17 28e. Place of Injury - At home	mel 14	00	Yes 2 No	28t Location (St				
Division	or All after of Direction by	Certification:	4 Homicide determined	huilding ato (Specify)		leuce		City or Town	, State) 65 1-5	Rural Route Number, C4 r Camu XPA		
	To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical Co	(Check only 2 X Medical Exam	sician: To the best of my knowled iner: On the basis of examination	dge, deat	h occurred at the tim	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and di	Indian Had as state Mary land ue to the cause(s)		
	the hin 24 the F	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	2	9d. Date signed (Mor	oth Day Year)		
			250. Signature and little of certifier	11.2AC	2.	0.C.M			July 24, 2			
	12		20 Name and address of sames who	ompleted cause of death (from 03)							
			30. Name and address of person who co			11 Penn S	Street, B	altimore	, Maryland	1 21201		
	Sta Regist		31. Date filed (Month, Day, Year) JUL 29 20	32. Begistrar's Signature	19	Spark						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 10:45P M Efthymios Kaiser Courtis July 27 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1ÑM 2□F Illinois 79 Director 579-38-9806 March 15, 1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 28a-f show the Medical Examiner must be notified at Silver Spring 1√2 Yes 2 □ No Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 23a 3371 Beaverwood Ln. 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2X Married 0 1 ☐ Yes 2 ☑ No Specify: Specify. þ White 3 ☐ Widowed 4 ☐ Divorced "natural" eted 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Compi than Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Owner Restaurant 6th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 Is marked of Spero Courtis Elizabeth Tott 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Rigakos- Daughter 4206 Tulare Dr. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ¶ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation , 5 ☐ Other (Specify) Parklawn Mem. Park 07/30/2004 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, Part1. 5 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition **Physician** CARDIOMYOPATHY TSCHEMIC resulting in death) /Medical Due to (or as a consequence of): Examiner ACCID ENT EREBROVASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of) use as the burialthe attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy ò Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the at the detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No 2 No 1 Yes 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 25/No 1 Inpatient 1 ☐ Yes P 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident М 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Datę signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D-27660 MID. 7/29/04 ana 9 ROCKNILLE PILE RV, MD20852 30. Name and address of person w o completed cause of death (Item 23a) (Type, Print) SWAMI M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 30 2004

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JULY 28, DOROTHY COHEN 2004 S. 5:55 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CASEY HOUSE - MONTGOMERY HOSPICE ROCKVILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 ☐ F MAY 1, 1928 WASHINGTON, DC Director 577-32-9902 76 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show traumatic event, the Medical Examiner must be notified at 1 TypYes 2 □ No Directo MARYLAND MONTGOMERY ROCKVILLE 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ö permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene Improvant: If them 27 is marked other than "natural", or items 23a any highry or other traumatic event, the Medical Examiner mass 200.8. 10401 GROSVENOR PLACE, #1025 20852 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ▼No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SECRETARY PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BENJAMIN SHAPIRO **GUSSIE** LERNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARAN J. LONDON, DAUGHTER 8909 WANDERING TRAIL WAY, POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS. 7/29/2004 OLNEY, MARYLAND 21. Signature of Fune at Service 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Part1 Enter the diseas shook, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** GLIOBLASTOMA MULTIFORME MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Completed by Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Year Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗶 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 2 □ No 1 Yes 2 X No 1 Yes Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cher (Specify) HOSPICE 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director: / 2 Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 0 within 24 hours a 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number MD42452 JULY 28, 2004 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHITRA RAJAGOPAL, M.D., 18111 PRINCE PHILIP DRIVE, #327 OLNEY, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 JUL Reserva Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** William M COSO OYEC GEOR てののみ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 511 Monteomers 1021 Gr UPY 66 yours 8. Date of Birth (Month, Day, Year) Feb. 2, 1939 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1⊠M 2□F 65 389-36-2111 Director Wisconsin Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Example retrieval to confilled as any injury or other traumatic event, the Medical Example retrieval to confilled as any injury or other traumatic event, the Medical Example retrieval to confilled as any injury or other traumatic event, the Medical Example retrieval. 1 ☐ Yes 2 No Silver Spring Montgomery Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 10217 Greenacres Drive USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 19 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1960 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) Special Education Teacher College (1-4or 5+) Elementary/Secondary (0-12) P.G.Schools 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leona Bennett William Conroy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Silver Spring, Md 10217 Greenacres Amelia Ann Conroy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State '4 □Donation 5 □Other (Specify)

1. Signulus of Every Bessemer Cemetery 8/02/04 Bessemer, N.C. 21. Signature of Funeral Service Lic-PHILIP OF RIWALDI FUNERAL SERVICE 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner , Xen Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit d and Due to (or as a con souence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year detached for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☐ No 9☐ Unknown 9 I Unknown þ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. should be 1 ∏ Yes 2 □ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

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1 XYes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 5 Residence 6 □Other (Specify) ٩ 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this s after death.
I Director: After this of in by the funeral di 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural
2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Or the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of gertifier 2 K D00428 che 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECKER mo Oruc= 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 30 Registrar

			For State	State of Ma	•	epartment of H De <i>rtificate of L</i>			0.0	01 050
			Registrar 1. Decedent's Name (First, Middle,	Last)		serimente or i	Jean	2. Date of Dea	_	3. Time of Death
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Ne		197	207 LAKES		e (In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birt		9. Birthplace (State or Foreign
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	r dea	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- American Indian, c, White, etc.
36	72 hours after death with the Maryland natural', or Items 23e or 28e-f ahow dical Examinet must be notified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 ☐ Yes 2 XX h If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🛣 No	Specify:		Specify:	WHITE
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	and 2 saith a n 27 is		JOHN A. CO	PER/BROTHER			MOUNTAI		RUSTBURG	, VA. 24588
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important; if item 27 is marked other than "natural; or Items 23e or 28a-f ahow any injury or other treumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 【Cremation	3 □Removal from State		Disposition (Name of crematory or other place	e)	Date	20c. Location - 0	City or Town, State
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	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and	death occurred at the tim or investigation, in my op	ne, date and place pinion, death occur	, and due to the orred at the time, o	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amount injury or other traumatic event, the Moderal Examinational Louising and Once.	by Fune	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 h If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub		ecify Yes or No- Rican, etc.)	Black, W	merican Indian, Thite, etc. White
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.) 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Month Day Year **Physician** July 28. 12:45am M Doris Ruth Davis 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Casey House Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 6. Sex Birthplace (State or Foreign Country) Months 1 ☐ M 2 🖾 F Director 334-18-9666M 87 24, 1916 Illinois Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 ie markad other than "natural", or itams 23a or 28a-f ehow amortant: If item 27 ie markad other than "natural", or itams 23a or 28a-f ehow amortant in jury or other traumatic event, the Medical Examinat must be notified at once. 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Bethesda Directo Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 6105 Melvern Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ð ^{Specify:} African American If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary State of Illinois 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ferdinand Nathaniel Smith CarrieBell Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 6105 Melvern Drive, Bethesda, MD 20817 Chester Davis, II 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State de Cemetery Aug. 5, 2004 Aurora,
22. Name and Address of Facility DeVol Funeral Home
10 East Deer Park Drive
Gaithersburg, MD 20877 ' 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery Aurora, Illinois 21. Signature of Funeral Service Licens complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com-shack, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Alzheimer's Dementia Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): burial-transit death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1☐Yes 2X No Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 X No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 SOther (Specify) Hospice 2 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 ho a D 42452 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Rajagopal, MD 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

29

2004

JUL

Darks

		1 - For State Registrar	State	of Marylan		artmen rtificate					giene Reg. No.20	04	2540
Physici	an	1. Decedent's Name (First, Middle	e, Last)				_			2. Date of De Month	Day	Year	3. Time of Death
/Medi		Beverly	Deems							July	15, 20		12:00 A
Examir	ıer	4a. Facility Name (If not institution				1		Location of			4c. County		
		Wilson Healtl			Inna hindhala sa	Gail If Under		sburg		O Date of Bir	Mont	<u> </u>	
Funeral Director		5. Social Security Number 578–07–6859	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 90	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	7, 1913	Wast	place (State or Fore ntry) nington,
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	Od. Inside City Lim
Maryl f sho	ō	Maryland Mante	tomoru	Roy	kville	3							1 ∑ Yes 2 □ I
289-	Directo	Maryland Mont	gomery	RO	CKATTTE	10f. Zip	Code		-		10g. Citizen of V	Vhat Cou	ntry?
with 3s or		4320 Prince Ros	a d				353-1	1301			U. S.		
deeth ms 2:	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)		e - Americ	can Indian,
after or ite		1 Never Married 2 Marr	ied 1 ☐ Yes	2 X No					i, Puerto	Hican, etc.)		k, White,	
ral', c	1 by	3 Widowed 4 Divorced	If Yes, G Year or I	Dates:		1 ☐ Yes 2	Z X NO	Specify:			Specify	· Whi	
be tiled within 72 hours after deeth with the Maryland tal Hygiene. d other than *natural; or items 23s or 28s-f show svent, the Medical Exertilise must be notified at	Completed	15. Deceden (Specify only higher)	16a. Deced	kind of wor	k done d	lurina mos	t of worki	ng	16b. Kind of Bu	ısiness/In	dustry
Althin De.	I du	Elementary/Secondary (0-12)	College	(1-4or 5+)	Homer	DO NOT us	e retired,)			Own H	ОПІА	
led w tygien her ti		12 Years 17. Father's Name (First, Middle,	(act)		помет	uakei		19 Mothe	rée Name	/Eimt Middle	, Maiden Suman		
be ti	Be		Last)									10)	
of 2 should be tiled within 72 hours at tilt and Mental Hygiene. 27 is marked other than "natural", or traumatic svant, Ina Medical Examp	2	Oliver Foulk 19a. Informant's Name/Relations	hin /Tuna (Print)		10b Mailie	Addross	(Stroot #	011		UNKNOW	er, City or Town,	State Zie	Codol
permit. Peges 1 and 2 should be t Department of Health and Mental t Importent: If item 27 is marked of sny injury or other traumatic ava once.		Richard F. Wei				-					Marylan		,
s 1 and 2 of Health a item 27 is		20a. Method of Disposition	510 0011	20b. F	Place of Dispo	sition (Nan	ne of	I		ate	20c. Location -		
Peges Int: If it		1 Burial 2 XCremation		State	emetery, crer	-						ni na na kasan	
intransporter		 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service 		NA'	CIONAL	CREMA	ATOR I	OM J	ULY :	26, 200	4 FALLS	CHUE	CH, VA
permit. Peges 1 ar Department of Hea Importent: If item sny Injury or othe once.) Domld (1 ()+	Atten	yes_	Edware	d Sa	gel F	uner	al Dire	ection, cville,	Inc.	20852
Physician /Medical Examiner	Jer.	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any landing to immediate cause. Enter Underlying	a Due to	(or as a conseq	emer uence of):	7	o or dywrg	, such as	cardiac	i i espiratory a	11051,		Approximate Interval Between Onset and Death
The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	cause. Enter underrying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):								
at the death certifica by the attending phatached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	itcome of pregna birth 2 ☐ Feta nant at time of d	Ideath 3□	Ectopic pre Other (spe					23d. Dat Moi	e of delive	Day Year
w requires that been signed I should be det	by	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlying ca	ause give	n in Part I.				ibute to th	ably 4 Unknow
	Completed									24a. Was autop perfo 1 Yes	rmed3	rior to cor leath?	psy findings availab npletion of cause o
ician Sartifi Botor,	Be	25. Was case referred to medical examiner?	Hoenital				O-1		of Death	(Check only o	ne)		
Physician: r this certitica ral director, p	10	1 Yes 2 No			ER/Outpatien			4 Nu			dence 6 Othe		/)
ling After	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		of Injury oth, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ′es 2⊡!		od. Describe i	now injury occurr	₽Œ	
deatl deatl ctor: y the	Certificati	2 Accident investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Plac	e of Injury - At ho ling, etc. (Specif	ome, farm, str			65 2		28f. Location (S City or Tov	Street and Numbern, State)	er or Rura	l Route Number,
To the Hospitel or / within 24 hours after To the Funerel Dire ompletely tilled in b	Medical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examiner: On the t and mar	e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the	cause(s) and ma date and place, a	nner as st and due to	ated. the cause(s)
To th within To th	Me	29b. Signature and title dertifier	0			29c	. License	number			29d. Date signed	(Month,	Day, Year)
10) It	1)1		MO	(0.2	0198	}		Plac	15	2004
, •		30. Name and address of person	who completed cau	se of death (Item	23a) (Type,	Print)	-		-	1		<u> </u>	
		Steven D)olins/21	911	Russ	011 A	ruc,	621	thers	burg	md.	20	879
Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Signa	ture g	Spa	stal	,)			

Jean Louise Denka Baltimore, Maryland 21215-0036

		1_ For	Please			k Indelible ink Department of I Certificate of	Health and	Mental Hyg	giene	
Physic		1. Decedent's N	ame (First, Middle, La	L.	DENKA	Certificate of	Deain	2. Date of Dea	th 2004 Day Year	3. Time by Death 4 (0:50 p)
/Med Exam Funera Directo	iner		-5028	NITY HOSP		L		s. 8. Date of Birth	4c. County of Dea PRINCE G PRINCE G 9. Birl Cc Cc WA	
Maryland -1 show fled at	tor	10a. State	10b. County PRINCE G	EORGES	10c. City, Tov	vn or Location	RDALE			10d. Inside City Limits TYPES 2 □ No
with the 3s or 28s	I Director	10e. Street and 461	Number			10f. Zip Code	20737		U.S.A.	ountry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show eny injury or other treumatic event, Its Modical Exam natural be notified at none.	by Funeral		us Married 2 X Married id 4Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s?]No	13. Was Decedent of If Yes, specify Cub		Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
ed within 72 hours aft giene. er then "natural", or the Medical Exent	Completed		15. Decedent's Expecify only highest gradecondary (0-12)	ducation ade completed) College (1-40		L. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of wo	orking	16b. Kind of Business	
e filed wil al Hygien I other th vent, the	Be Con		12 ne (First, Middle, Last,)		HOMEMAK		me (First, Middle,	HOME Maiden Sumame)	
id 2 should be file Ith and Mental Hy 27 is marked oth treumatic event	To	19a. Informant's	JAMES s Name/Relationship (MONTE Type, Print)		b. Mailing Address (Street		LORANCE Jural Route Number	WILSON r, City or Town, State, 2	Zip Code)
Permit. Pages 1 and 2. Department of Health at mportent: If item 27 is any injury or other treuse.		20a. Method of 1	Disposition 2 Cremation 3	HUSBAND Removal from State	e cemete	of Disposition (Name of ery, crematory or other pla	ace)	Date	MD. 2073 20c. Location - City or	Town, State
permit. Pa Departmen Importent: eny injury		° 4 □ Donatio	on 5 Other (Specific Funeral Service Cicer	y)	CHAM M00091	BERS CREMATO 22. Name and Addro CHAMBERS	ess of Facility	-	RIVERDALE EMATORIUM, DALE, MD.	
Care the process of the principle of the purish-transit as the burial-transit as the purish-transit as the pur	Examiner	shock, or I Immediate Cau disease or cond resulting in dea Sequentially list if any, leading to Cause (Disease that initiated ever resulting in deat	dition th) t conditions, o immediate noudying or injury ents	aDue to (or a bDue to (or a c.	is a consequence	of):	Sy	ndinme		Interval Between Onset and Death
that the death certificate bed by the attending physic	Physician/Medical	IF FEMALE: 23b. Was deceded in the past 1 Yes 9 Unknown	12 months?		2 Fetal death at time of death	n 3 □Ectopic pregnanc 5 □ Other <i>(specify)</i> _	y		23d. Date of del Month	ivery Day Year
The law requires ate has been sign page 2 should be	Completed by Ph	Part II. Other sig	Heavy Hyper	contributing to death	but not resulting	in the underlying cause gr	ven in Part I.	1 24a. Was a autops perform	24b. Were au prior to death?	othe cause of death? obably 4 Unknow otopsy findings availab completion of cause of
ysicien: is certified director	To Be	examiner? 1 Yes 2 27. Manner of D 1 Natural 2 Acciden	Death 5 Pending investigation			Time of 28c. Inju	her: 4 Nursing	,	e) ence 6 Other (Spec ow injury occurred	cify)
tel or Atters after de el Directo	Certification:	3 ☐ Suicide 4 ☐ Homici		Zoe. Place of t	njury - At home, f etc. <i>(Specify)</i>	arm, street, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 29b. Signature			of examination a	e, death occurred at the tind/or investigation, in my 29c. Licen	opinion, death occ	urred at the time, d	ate and place, and due	to the cause(s)
5		•	AHG,	completed cause of	death (Item 23a)	MD D	19599	93 Rd L	7,25	e7
	tata	AMG	Month, Day, Year)	M 5 1977 [strar's Signature	8- Good	Luck	Rd L	in ham	MD 207
S Regis	tate trar			104 /200	una /	3 sporks				

		•	For State Registrar	State of	Marylan		artmen rtificat			and M	ental Hy	giene Reg. No.2	004	25402
			1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Anna	L		DiGiov	anni				July 2	,	003	5:00 P M
	Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City,	Town, or	Location of	of Death		4c. C	ounty of Dea	th
			Calvert Memoria						Fred				alvert	
	Funeral			. Sex 7 1 □ M 2 🔀 F	'. Age (In yrs.	last birthday) Yrs.	Months	1 Year Days	If Under:	Min.	8. Date of Birt (Month, Da	y, Year)	, Co	thplace (State or Foreign ountry)
	Director	}	Usual Residence of Decedent		79	115.					Sept. 4	, 192	24 Nev	v York
	and wo		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	Maryland Calver	· +	т	usby								1X Yes 2 □ No
	28e	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	ountry?
	3e or	₫	12112 Catalina	Drive			2	0657	7			U.S	S. A.	
	death	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	.S. 13.				gin? (Spe	cify Yes or No Rican, etc.)		1. Race - Ame	
9	or ite		1 ☐ Never Married 2 ☐ Marrie	Armed Ford 1 ☐ Yes 2 If Yes, Give	2] ∑ No	ļ	Tes,spec 1 □ Yes :		n, mexican Specify:	i, Puerto F	rican, etc.)		Black, Whit	te, etc.
5-0036	hours after death with the Maryland tural', or Items 23e or 28e-f show al Evanities must be multified at	d by	3 X Widowed 4 □ Divorced	Year or Dat	les:		1 1 1 0 5	2 <u>A</u> J 140	зреспу.				Specify:	White
ည်	22 8 3	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Dece	kind of wo	k done d	turina most	t of workin	ıg .	16b. Kind	d of Business	/Industry
2	within lene. than	Id II	Elementary/Secondary (0-12)	College (1-	4or 5+)		oo not us emake)			0	II	
2	filed v Hygie other t		17. Father's Name (First, Middle, La	net)		ПОШ	emake	:L	18 Mothe	r'e Namo	(First, Middle,		n Home	2
ב	0 E C S	Be		,								MaluellS	инання)	
Ĕ	should and Men marke umatic	၉	Frank Calavieri 19a. Informant's Name/Relationshi			10h Mailir	a Addross	(Stroot o			almeri Route Numbe	r City or	Tour State	Zin Codo)
Maryland	nd 2 sl alth an 27 is r r treur		Arlene Dmuchows		ter)		•				ineola			zip Code)
	4 6 5		20a, Method of Disposition	KI (Daugi		Place of Dispo					ate		ation - City or	Town, State
Baltimore,	mit. Pages 1 partment of He portent: If Iter y Injury or oth		1 XBurial 2 ☐ Cremation 3		iaie .	emetery, crer y Rood				7/20	2004			
틀	rtment njury		*4 □Donation 5 □ Other (Special Service Li		1101	-		_	s of Facility		2004	wes	tbury,	NI
Ba	permit. Departm Importe any inju		21. Signature of Political Service Es	1	A		Thoma	s F,	Dalt	on F	uneral			1175
			23a. Part1. Enter the disease, or co	omplications that ca	used the deat								ttown,	NY 11756 Approximate
			shock, or heart failure. List or Immediate Cause (Final	nly one cause on ea	ch line.							,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Methi	r as a conseq	- nesis	tunt	STAP	hylou	acen	i junea	: in	docardi	is 3 weeks
	Examiner			D	~ ~ o,									3 week
		ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		r as a conseq									
	cuted nd ransit	Examin	that initiated events	. Seve	re v	heum	atoic	2 0	erth	べら	5			many years
o,	en ar en ar urial-t	EX	resulting in death) Last	Due to (o	r as a conseq	uence of):								
8760	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	dical		d. Vriv	nary	bili	wy.	<u>cì</u>	rrh	دزود				many years
ف	leath certific attending p	ĕ	IF FEMALE:											
Box	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 🗀 Feta	il death 3□	Ectopic pr					23	d. Date of del Month	ivery Day Year
0	the a	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	4∐Pregna 9∏Unknov	nt at time of d vn	leath 5∟	Other (sp	ecify)						,
J.	res that the de signed by the a I be detached f		Part II. Dther significant condition	s contributing to dea	th but not res	ulting in the u	nderlying c	ause dive	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ecords,	signe d be	d by	Congective here	of fails	line.		, ,				101	'es 2 2	No 3□Pr	obably 4 Unknown
ö	w require been si should b	ete	0 1-7-6	. 1	1	1 16	1				24a. Was	20	24h Wara au	itopsy findings available
Ř	o	Completed	De cubitos of	cer of	tace	Crigio)				autop	sy med?	prior to death?	completion of cause of
Vital R	ilcien: Th certificate rector, paç	မ င	25. Was case referred to medical	throm	605,5				OC Diago	of Dooth	1 ☐ Yes (Check only o	2JZ No	1 ☐ Yes	212 No
	iysicien: iis certific director,	o B	examiner?	Hospital:	patient 2	ER/Outpatien	t 3 🗆 DO	Othe			e 5 ☐ Resid		Other (Spe	cife)
ō	5 E E	Ηŝ	27. Manner of Death	28a. Date of	Injury	28b. Time of	_	8c. Injury	at		8d. Describe h			cuy,
0	nding f ith. :: After e funer	igi	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		, Day Year)	Injury	М	Work	r ∕es 2 🗖 l	Vo				
Division	Attendir r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 289. Place C	of Injury - At he	ome, farm, str	eet, factory	, office		2	8f. Location (S		Number or Ru	ıral Route Number,
	s afte	Certification:	Tomedo /	Daliani	g, etc. (<i>Specii</i>	y /					Ony or Ton	n, State)		
	To the Hospitel or Attend within 24 hours after deatl To the Funerel Director: completely filled in by the	cal	29a. Certifier 1 Certifying	Physician: To the base	est of my kno	wledge, death	occurred	at the tim	e, date and	d place, a	nd due to the o	cause(s) ar	nd manner as	stated.
	the H in 24 the F	ledical	one)	and manne	er stated.									
	To To	Σ	29b. Signature and title of certifier	. /			290	,	number			zed. Date	signed (Monti	n. vay, Year)
	4			WO /H	USPITA		U	60	390)			21/	7
	-		30. Name and address of derson w		of death (Item		Print)	2.0	0	1000	Fre	00.0	26	MO 2067A
	Sta	to	31. Date filed (Month, Day, Year)	FBER 32. Re	gistrar's Signa	HUSO T	in 1	-41	ir	ince	. // 2	~ ~ 1	1	20018
	Sta Registr		MI 27 2	004	green production of the second	19	400	E of the said						

			1 - For State Registrar		of Marylar	nd / Depa		t of H	ealth a		•	Hygi	ene 2.00	lı	25403
			Decedent's Name (First, Middle, Las	')							2. Date o		j. 140	,	3. Time of Death
ı	Physici		Lucille R. Dun	ayer							Month July	26	, Day 200	Year 4	10:05 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and nu	ımber)		4b. City,	Town, or	Location of	f Death			4c. County	ol Death	
ı			Shady Grove Adve	ntist	Nursing	Ctr.	R	ockv:	ille				Mon	tgon	nery
	Funeral		Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date o	f Birth	(ear)	9. Birth	nplace (State or Foreign untry)
	Director		124-10-4208	_M 2 ⊠ F	84	Yrs.	INOTHIS	Days	110010	141411.	July	15,	1920	Ne	
	put		Usual Residence of Decedent 10a. State 10b. County		10c. Cir	ty, Town or Lo	cation							— Т	10d. Inside City Limits
	sho	ō						·							1 ☐ Yes 2 🛣 No
	the N	ect	Maryland Montgo 10e. Street and Number	шегу		Silve	10f. Zip					10	g. Citizen of V	What Co	intar?
	with the or	ā	531 Randolph Roa	a				904							
	leath	era	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.1	Was Deced		spanic Ori	gin? (Spe	cify Yes c	r No-	USA 14. Rac		ican Indian,
0	ritar	F	1 ☐ Never Married 2 ☐ Married		2 🔀 No					, Puerto I	Rican, etc	.)		k, White	
9	al', o	by	3 Widowed 4 □ Divorced	If Yes, G Year or [1 🗆 Yes	2%_] No	Specify:				Specify	WHI!	re
2	within 72 hours after death with the Maryland ene. than "natural", or itams 23e or 28e-f show fe Madical Exerciter must be rediffed at	ted	15. Decedent's Ed (Specify only highest grad			16a. Dece	dent's Usua	al Occupa	ation	t of worki	na	10	b. Kind of B	siness/l	ndustry
2	ithin be.	nple	Elementary/Secondary (0-12)		(1-4or 5+)		kind of wo DO NOT us)						
2	ed w ygier ygier yer th	Co	12			Cle	rical		40.14.4		<i>(</i> =		Busir		
n L	be fill d oth	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Mi	ddie, Ma	aiden Suman	10)	
<u> </u>	ould Mer narke	P.	Samuel Hauseman	D.:1		105 14-16	- 4 4 4	/041			Levy		3.4 T	01-1- 7	. 0. (1)
Maryland 21215-0036	12 st h and 7 is n traun	0.8	19a. Informant's Name/Relationship (7 Ruth Foster/ Dauc				-						City or Town,		
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avant, the Marical Exercited must be notified at once.		20a. Method of Disposition	nter	20b. F	Place of Dispo	sition (Nar	ne of			ary 2		c. Location -		1D 20850 own State
jo	or and or	1 3	1 ⊠ Burial 2 ☐ Cremation 3 ☐		State	cemetery, cred Jud	natory`or o ean	ther place	9)		11y 2	10			
Baltimore,	it. P.		 '4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License 		Me	morial			s of Facilit			_	lney,		/ Iana
Ba	Deportant any any any any any any any any any any		V. 54.0.			F	ranci	s J.	Coll	ins	Fune	ral	Home 1	nc,	ng, MD 20901
	Prysician /Medical Examiner	ner	23a. Plan. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unexase or #jury	a. Lung Due to	caused the deal each line. Cancer (or as a consect of consect	quence of):	er the mod	e of dying	g, such as	cardiac o	r respirato	ory arres	t,		Approximate Interval Between Onset and Death 1 Year
68760,	tificate be executed ig physician and as the burial-transit	ledicai Examiner	that initiated events resulting in death) Last	c											
.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregnation to the pregnant at time of controls of the pregnant at time of controls of the pregnant at time of controls of the pregnant at time of controls of the pregnant at time of the pr	al death 3	Ectopic pr Other (sp						23d. Dat Mo		very Day Year
S, D	uires that i signed bi ld be deta	by	Part II. Other significant conditions co			•	, ,	•	n in Part I.						the cause of death?
Record	w requir been si should	Completed			•						24a. \	√asan	24b. \	Vere aut	opsy findings available
Be	he la e has age 2	mc d									F	utopsy erforme	id? c	leath?	ompletion of cause of
Vital		0	25. Was case referred to medical					-	26 Place	of Death	(Check o	es 2		Yes	2L No
>	Physician: The lav this certificate has ral director, page 2	0 B	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	Othe					ce 6 □Oth	er (Speci	(fv)
ion of	ding Ph h. After th funeral	ation: T	27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation	28a. Date		28b. Time of Injury		8c. Injury Work	at (? (es 2 🗆 1	2			injury occurr		
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	286. Plac	e of Injury - At h ding, etc. (Speci	ome, larm, str fy)	eet, factory	, office		2		on (Stre r Town,		er or Rur	al Route Number,
	To the Hospital or within 24 hours after To the Funaral Dir completely filled in	Medical	29a. Certifying Physics (Check only one)	iner: On the I	e best of my kno basis of examina nner stated.	owledge, deatl ation and/or in	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	and due to ed at the ti	the cau me, dat	se(s) and ma and place, a	nner as : and due	stated. to the cause(s)
	To the vithin 2. To the I complet	Σ	29b. Signature and title of certifier				290	. License					. Date signed		
	10		Day.					D28	056				July	27,	2004
	1 4		30. Name and address of person who												
			Ravi Passi, M.D.				4			kvil	le, N	1D 2	0850		
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 8 20		Registrar's Sign	G	Spo	uka	1						

			For State	State of N	faryland / D	epartme Certifica			nd Mental	Hygie Reg.	0001	251.01.
			Registrar 1. Decedent's Name (First, Middl	e. Last)		Jerimoa	10 01 1	Jean	2. Date	of Death	No.U U 14	3. Time of Death
	Physicia		Janet W. Davis	-,,					Mon .T11 T s	th 27,	2004 Year	
	/Medic Examin		4a. Facility Name (If not institution	n, give street and numbe	r)	4b. Cit	, Town, or	Location of			4c. County of De	
	LAdilliii	٠,	8505 Buckhannon	Drive		Pot	omac				Montgome	ery
	Funeral		5. Social Security Number		Age (In yrs. last birth	Months	or 1 Year Days	If Under 24 Hours	4 Hrs. 8 Date Min. (Mon	of Birth	9. Bi	irthplace (State or Foreign Country)
	Director		219-22-5857	1 □ M 2 😿 F	77 Y	rs.			Apri	th. Day. Ye	1927 Mar	ryland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary -f sho	to	Maryland Monte	omery	Potomac	2						1 ☐ Yes 21⁄2 No
	r 28a	Funeral Director	10e. Street and Number	,02.02.			ip Code			10g.	Citizen of What C	Country?
	738 o	ai D	8505 Buckhannor	Drive		2	0854			Un	ited Sta	tes
	ems ems	ner	11. Marital Status	12. Was Deceder Armed Forces		13. Was Dec	edent of H	ispanic Origi n, Mexican,	in? (Specify Yes Puerto Rican, e	or No-	14. Race - Am Black, Wh	
36	s after	by Fu	1 Never Married 2 Mar	If Yes, Give	-	1 🗆 Yes	2X No	Specify:			Specify: W	
21215-0036	within 72 hours after death with the Maryland ene. Than "netural", or items 23a or 28a-f show he Medical Examiner must be notitied at	ed b	3 ☑ Widowed 4 ☐ Divorced	Year or Dates	16a.	Decedent's Us	ual Occup	ation		160	o. Kind of Busines	s/Industry
5	n "ne	Completed		st grade completed) Coilege (1-4o		(Give kind of w life. DO NOT	ork done o	during most o	of working			,
212	d with giene er tha	mo:	Elementary/Secondary (0°12)	4		nemaker				70	wn Home	
pu	al Hy al Hy d other	Be	17. Father's Name (First, Middle,						's Name (First, I		den Sumame)	
yla	Duld to Ment arkec atic e	2	Herbert T. Will						n T. Jacl			
Mar	d 2 sh th and 7 ts m traum		19a. Informant's Name/Relations Kennon E. Davis								ity or Town, State, Marylane	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or items 23a or 28a-f show amount injury goother traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation		20b. Place of	Disposition (N	ame of		uly 31,	200	. Location - City o	
E m	nit. Pag vartment ortant: injurys		* 4 ☐ Donation	Specify)	Cremăt	orium.	Inc.		2004	A P111	mnhrev Fi	uneral Home/
Ba	Depared Important Important Information In		POR	369	M01346	Rockvi Rockvi	lle, lle,	Inc. Maryl	300 West and 208	Moni 50	tgomery	uneral Home/ Avenue
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that caus only one cause on each	ed the death. Do n							Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	a Atheros	clerotic	Cardio	vascu	ılar D	isease			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequ <i>e</i> nce o	f):						
		er	Sequentially list conditions, if any, leading to immediate cause E. Tor Underlying Cause (Disease or injury	b. Due to (or a	is a consequence of	f):						
	cuted nd ransit	Examiner	that initiated events	c								
ő,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or a	as a consequence o	f):						
8760,	cate b physic the b	dical		d								
9 X	eath certific attending p	ian/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnancy						23d. Date of de	elivery
Вох	the death certificate y the attending phys iched for use as the	ciar	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No		2 Fetal death at time of death	3 □Ectopic 5 □ Other (Month	Day Year
0		Physicia	9 ☐ Unknown	9□ Unknown								
٦,	requires that een signed b	by P	Part II. Other significant conditi	ons contributing to death	but not resulting in	the underlying	cause giv	en in Part I.	23e	. Did tobac	co use contribute	to the cause of death?
ord	w require been sig should t								- 100	1 🗌 Yes	2 X No 3 ☐ F	Probably 4 Unknown
ecords,	as b	ompieted							24a	. Was an autopsy	prior to	autopsy findings available completion of cause of
$\mathbf{\Xi}$	Th ate pag	Соп							10	performed Yes 2X	d? death? No 1 ☐ Ye	s 2□ No
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	of Death (Check			
of	hys dir	- To	1 X Yes 2 ☐ No 27. Manner of Death	28a. Date of Ir			28c. Injun	4 🗀 (40) 3			e 6 Other (Sp injury occurred	ecify)
	iding th. : After fune	tion	1 XNatural 5 ☐ Pendi	(Manath I		jury M	Wor	k? Yes 2 ⊡ N			,,	
Division	ial or Attending Pis after death. I Director; After to by the funera	ertification;	3 Suicide 6 Could 4 Homicide	not be 28e. Place of I	njury - At home, far	m, street, facto	ory, office			tion (Stree or Town, S		Ru <i>ral Route Number</i> ,
Ö	tal or rs afte al Dir	O	4 - Horricide	building,	etc. (Specify)				Olly	0/ 10#//, 3	nato)	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical		ng Physician: To the be Examiner: On the basis and manner	of examination and							
	To the within 2 To the complet	Me	29b. Signature and title of certifie	or 1	m 1	20 2	9c. Licens				Date signed (Mor	
	12		Patricia	lowskee	May,	160	D5191	L6		Ju.	ly 28, 20	004
	()		30. Name and address of person Patricia Tomsko				ond	D 0 0 1	4110 2	0 20 1	na 20852	
	Sta	ite	31. Date filed (Month, Day, Year	32. Regis	strar's Signature		road,		е, М	arytai	на 20052	
	Registi	rar	AUG 0 5	2004	/	19	1 CHENTS					

			For State Registrar		ryland / De		Health and	d Mental Hyg	giene	25405
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		Helen Agnes Darl	ling					5, 2004	3:25 a ^M
j.	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of De	eath	4c. County of Deat	th
			Montgomery Hospic			Rockv			Montgor	mery
	Funeral Director		5. Social Security Number 217-70-3879 Usual Residence of Decedent	7. Age	(In yrs. last birtho	Months Dav		frs. 8. Date of Birtl lin. (Month, Day Oct. 18	v, Year) Co	thplace (State or Foreign puntry) shington, DC
	and		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Marylan 9-f show	tor	Maryland Montgor	nery	Silver	Spring				1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	th wil	alc	3576 Chiswick Cour	rt, #2B		2090	6		USA	
	ems	nei	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of If Yes, specify Cu 	Hispanic Origin? ban, Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Ided other than "natural", or Items 23a or 28e-f show event, the Medical Examinar must be notified at	by Fu	1 Never Married 2 Married 3	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🙀 No			Specific	nite
우	tura cal E	pa	15. Decedent's Edu	ucation	16a. D	ecedent's Usual Occi	upation		16b. Kind of Business	
15	n "ng	Completed	(Specify only highest grad	de com <i>pleted)</i> College (1-4or 5-	- li	Rive kind of work don fe. DO NOT use retir	e during most of (red)	working		,
7	d withing giene.	mo	12	Conaga (1-40) 54		omemaker			Own Home	
힏	e filed al Hygi other vent, t	Be C	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle,	Maiden Sumame)	
<u>a</u>	Ments Ments arked arked	10	Ignazio Amato				Rosin	a DiCrist	ina	
Maryland 21215-0036	s 1 and 2 should be f Health and Mental H Item 27 Is marked of other treumatic eve		19a. Informant's Name/Relationship (T)			,			r, City or Town, State, 2	Zip Code)
	s 1 and 3 f Health item 27 other tr		William A. Darli	ing/ son			ue Lane,	Wheaton,		T 01-1-
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 D	Removal from State	cemetery,	isposition (Name of crematory or other pi te of Heav	ven ' ^	ugust 9,	20c. Location - City or	Town, State
턆	permit. Page Department of Important: If any injury or once.		 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens 		1	Cemetery 22. Name an Add		004	Silver Spri	ing, MD
Ba	Depar Depar Impor any in		21. Signature pri Puliarai Service Etcans	Souls		Francis J	. Collin		Home Inc.	og MD 20901
2	Provided and Medical Examiner provided transit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Myclody Due to (or as a b. Due to (or as a						Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be delached for use as the burial	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	d	2 Fetal death	3 □ Ectopic pregnan 5 □ Other (specify)	су		23d. Date of del Month	ivery Day Year
s,	res tha	by	Part II. Dther significant conditions co Thalassemia Majo	_	t not resulting in th	e underlying cause g	iven in Part I.		bacco use contribute to es 2⊊No 3∏Pr	the cause of death? obably 4 Unknown
orc	w requires been signe should be	eted	Thatassemia haje	71					1	
al Records,	: The law cate has t page 2 s	Completed						24a. Was a autop: perfor	med? prior to death?	topsy findings available completion of cause of 2 No
Vital	lysician: Th lis certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			wt	Death (Check only or		
o	ding Phys h. After this funeral dii	ation; To	1 Yes 2 No 27. Manner of Death 1 Statural 5 Pending 2 Accident investigation	1 ☐ Inpatier 28a. Date of Injun (Month, Day	nt 2 ☐ ER/Outpa Year) 28b. Tim Inju	ie of 28c. Inj	4 Nursin		ence 6 X Other (Specow injury occurred	Facility
Division	al or Attendi s after death. Il Director: A id in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm . (Specify)	, street, factory, office	Э	28f. Location (S City or Tow	treet and Number or Ru n, State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after deation 24 hours after deation to the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 □ Certifying Phy (Check only one) 2 □ Medical Exam	vsician: To the best of iner: On the basis of and manner state	examination and/o	leath occurred at the or investigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time, o	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within To the Comple	M	29b. Signature and title of conflict	1/1		29c. Licer	nse number	2	9d. Date signed (Mont	h, Day, Year)
			Lett	Tac		$-\mid V \mid$	4121	8	815/1	24
	フ		30. Name and address of person who co	-		•	1-1-1	· · · · · · · · · · · · · · · · · · ·	0/1/	
			Charles Harrison,			er Mill Ro	oad, Roc	kville,MD	20855	
	Sta Regist		AUG 0 6 20	32. Registra		Spork	N			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician** Lester Royal Dauphin August 4, 2004 7:20 A.M. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Arden Court Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer)
Months Days Hours Min. Min. 17,1918 9. Birthplece (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Months 1**½** M 2□ F 86 073-14-0176 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location Maryland Montgomery Silver Spring 1⊠Yes 2□No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2505 Musgrove Road 20905 United States

uneral Director

parmit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be datached for use as the bunel-transit To the Hospital or Attending Physician: The law requires that the deeth certificate be axecuted

Division of Vital Records, P.O. Box 68760,

11. Marital Status	12. Was Decedent Ever in U,S Armed Forces?	S. 13. W	Vas Decedent of Yes, specify Cut	Hispanic Origin? (an, Mexican, Pue	Specify Yes or No- irto Rican, etc.)		ce - American Inc ck, White, etc.	dian,
1 Never Married 3€ Married	1√2 Yes 2 □ No If Yes, Give	1	☐ Yes 2X No	Specify:		Specif	y: White	
3 Widowed 4 Divorced	Year or Dates:1936-19	958					<u></u>	
15. Decedent's Edu (Specify only highest grad		16a. Deced	ent's Usual Occu kind of work done	pation during most of wo ed)	orking	16b. Kind of B	usiness/Industry	
Elementary/Secondary (0-12)	College (1-4or 5+)					_ 1		
12	2	Marke	ting Dir				l Credi	t Union
17. Fether's Neme (First, Middle, Last)				_	ame (First, Middle,		ne)	
Lester Dauphin				Maude	Morrill	_		
19a. Informant's Name/Relationship (T	vpe, Print)	19b. Mailin	g Address (Stree	t and Number or F	Rural Route Number	r, City or Town,	, State, Zip Code	9)
Amelia R. Dauphin/	Wife	1813	Middlev	ale Terr	ace, Whea	aton, M	D 2090	6
20a. Method of Disposition	20b. PI	lace of Dispos	sition (Name of natory or other pla	ica)		20c. Location	- City or Town, S	tate
1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ② Donation 5 ☐ Other (Specify,	Removal from State		. Univer		August 4 2004	Wachin	ngton, I) C
21. Planature of Funeral Service Licens	Med.	ical C	enter	ess of Facility		WasiiII	ngcon, i	J.C.
Date Constitution of the C	Zel	Wa:	olumbia shingtor .O. Box	Mortuary	Services 20037	, Inc.		
23a. Part 1. Enter the disease, or comp	lications that caused the death				ac or respiratory arr	est,		oximate
shock, or heart failure. List only o	ne cause on each line.						Ons	val Between et and Death
Immediate Cause (Final	Prostate Can	cor wit	th Motac	tacic to	the Pone	\C	1	
disease or condition resulting in death)	a	_		casis co	the Bone	:5		
	Due to (or	es a consequ	uence of):					
	b. Alzheimers D	isease						
Sequentially list conditions, if eny, leading to immediate	Due to (or	es e consequ	uence of):				į	
	. Hypertension						ĺ	
that initiated events resulting in death) Last		as e consequ	uence of):					
	B12 Dificiend	cv Aner	mia				i	
			ша				1	
		0, 1110	ша					
Part II. Other significant conditions co	ntributing to death but not resu			ven in Part I.	23b. Did to	obacco use co	ontribute to the	cause of death
Part II. Other significant conditions co	ntributing to death but not resu			ven in Part I.		obacco use co	entribute to the	
Part II. Other significant conditions co	ntributing to death but not resu			iven in Part I.				
Part II. Other significant conditions co	ntributing to death but not resu			iven in Part I.	1 □ Y	es 2 No	3 ☐ Probably	4 Unknow
Part II. Other significant conditions co	ntributing to death but not resu			ven in Part I.	1 🗆 Y	es 2 No	3 Probably 24b. Were au available	4 Unknow
Part II. Other significant conditions co	ntributing to death but not resu			ven in Part I.	1 □ Y 24a. Was a perfon	es 2 No n autopsy med?	3 Probably 24b. Were au available complet of death	4 Unknow stopsy findings a prior to ion of cause ?
	ntributing to death but not resu				1 □ Y	n autopsymed?	3 Probably 24b. Were au available complet of death	4 Unknow
25. Was case referred to medical examiner?	Hospital:	Ilting in the un	derlying cause g	26. Place of De	1 U Y	n autopsy med? 2 ₹No	3 ☐ Probably 24b. Were at available complet of death 1 ☐ Yes	4 Unknown topsy findings a prior to ion of cause? 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2♥☐ No	Hospital: 1 □ Inpatient 2 □ €	Iting in the un	derlying cause g	26. Place of De her: 4∐ Nursing	1 U Y 24a. Was a perform 1 U Y eath (Check only or Home 5 Reside	n autopsy med?	3 Probably 24b. Were at available complet of death 1 Yes	4 Unknown stopsy findings a prior to ion of cause ?
25. Was case referred to medical examiner? 1 ☐ Yes 2€ No 27. Manner of Deeth	Hospital:	Ilting in the un	t 3 DOA CO	26. Place of Do her: 4□ Nursing at ork?	1 U Y	n autopsy med?	3 Probably 24b. Were at available complet of death 1 Yes	topsy findings prior to ion of cause? 2□ No
25. Was case referred to medical examiner? 1 Yes No 27. Manner of Deeth 1 Setural 5 Pending investigation	Hospital: 1 Inpatient 2 2 8 28a. Date of Injury (Month, Day Year)	eER/Outpatient	t 3 DOA CO	26. Place of De her: 4∐ Nursing	1 U Y 24a. Was a perform 1 U Y eath (Check only or Home 5 Reside	n autopsy med?	3 Probably 24b. Were at available complet of death 1 Yes	utopsy findings prior to ion of cause?
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25. Was case referred to medical examiner? 1 Yes 20 No 27. Manner of Deeth 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	Hospital: 1 Inpatient 2 2 8 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	t 3 DOA O 28c. Inju W M 1[set, factory, office	26. Place of De her: 4□ Nursing iny at ork?] Yes 2□ No ime, date and place	24a. Was a performance. 24a. Was a performance. 24a. Was a performance.	n autopsy med? 2 3/Nu nee) ence 6 (20th ow injury occur treet and Numboundary, Stete) ause(s) and managements	3 ☐ Probably 24b. Were as available completed of death 1 ☐ Yes there (Specify) As a fired there or Rural Roule anner as stated.	topsy findings a prior to ion of cause? 2 No ssisted to Number,
25. Was case referred to medical examiner? 1 Yes No 27. Manner of Deeth 1 Acident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examined)	Hospital: 1 Inpatient 2 Is 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hos building, etc. (Specify, sicien: To the best of my knowner: On the basis of examinati	ER/Outpatient 28b. Time of Injury	t 3 DOA 28c. Inju W. M 1 Deet, factory, office estigation, in my	26. Place of De her: 4□ Nursing iny at ork?] Yes 2□ No ime, date and place	24a. Was a perform	in autopsymed? in autopsymed? as 2 XNo as 2 XNo as 6 XDth bow injury occur treet and Numb r, Stete) ause(s) and mate and place,	3 ☐ Probably 24b. Were as available completed of death 1 ☐ Yes there (Specify) As a fired there or Rural Roule anner as stated.	topsy findings a prior to ion of cause? 2 No ssisted ving te Number, cause(s)
25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 Is 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hos building, etc. (Specify, sicien: To the best of my knowner: On the basis of examinati	ER/Outpatient 28b. Time of Injury	t 3 DOA 28c. Inju WW 1 1 coet, factory, office occurred at the testigation, in my	26. Place of Doher: 4 \(\text{Nursing} \) Iny at ork? Yes 2 \(\text{No} \) Ime, date and place opinion, death occurs on the content of the content of the content occurs on the content occurs.	24a. Was a perform	in autopsymed? in autopsymed. in autopsymed.	3 ☐ Probably 24b. Were at available completed of death 1 ☐ Yes her (Specify) A: rred ber or Rural Route, and due to the conditions and due to the conditions.	atopsy findings a prior to ion of cause? 2 No ssisted te Number,

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 6 2004

pockal

32. Begistrar's Signature

P	MEND#7per	.FH8	3/6/04,BMW,MbCo	State of	t Marylar	•		of Death		Jiene eg. Ng. () () 4	25407		
	Physicia		1. Decedent's Name (First, Mid Ann W	idle, Last) Volff Donal	.dson			·	2. Date of Dea Month July	_	Year 004	3. Time of Death 4:50 pm		
1	/Medic Examin		4a Facility Name (If not instituti					4b. City, Town, or	Location of Death	4c. County		4.50 pm		
	Funeral Director		Maple 5. Social Security Number 073-16-3392	ewood Park 6. Sex 1 M 2 KF	Place 7. Age (In yrs. 85	last birthday)	If Under 1 Y Months D		s. 8. Date of Birth		tgome 9. Birthp Coun New	lace (State or Foreign		
	and w	F	Usual Residence of Decedent 10a. State 10b. Coun	ty	10c. Ci	ity, Town or Lo	cation				1	0d. Inside City Limits		
	with the Maryland a or 28a-f show be nulfited at	ţō	MD Mont	gomery]	Bethesd	.a					1 ☐ Yes 2 No		
	vith the	Director	10e. Street and Number				10f. Zip Co	de	1	0g. Citizen of V	What Cour	itry?		
020	or items 23	by Funeral	9707 Old Ge 11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Poivorce	12. Was Dece Armed Fo arried 1 Tyes	edent Ever in U rces? 2 17 No			14 of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	Blac	e - Americ ck, White, v: Whi	etc.		
Maryland 21215-0020	n 72 "nat	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)	ent's Education nest grade completed) College (1	-4or 5+)		lent's Usual O kind of work d DO NOT use n	ccupation one during most of we atired)	orking	16b. Kind of B		iustry		
d 2	i Hygie other	Be Co	17. Father's Name (First, Middle	e, Last)					Mother's Name (First, Middle, Maiden Surname)					
ylar	s 1 and 2 should be filed within f Health and Mentel Hygiene. Item 27 is marked other then "I other treumatic event, I'm Me	To E	Alfred D. Wo						na Belle					
	nd 2 sh lith and 27 is m	1	19a. Informant's Name/Relation Patricia D.		daughte			reet and Number or F ar Hill Ro						
Baltimore,	8 = t		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (n 3 □Removal from S	of Pplace) Crematory	Date	20c. Location -	City or To	wn, State					
Balt	permit. Pe Depertmen important: eny injury.		21. Signature of Funeral Service Welaure	Al III	ddress of Facility Funeral S	ervices	Thurah	37 A						
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that cast only one cause on e	aused the deal	th. Do not ente	er the mode of	dying, such as cardia	ac or respiratory arr	est,	V PA	Approximate Interval Between Onset and Death		
7	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. RES	SPIRI		y F	-AILUR			1			
	uted d ansit	aminer	Sequentially list conditions	b. FAL	LUKE	or as a conseq	0	THRIV	E					
68760,	tificete be executed g physician and as the buriel-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· ENI	Due to (c	TAG or as a consequ	E uence of):	DEME	NTIA					
_	01 10		,	d										
Box	death cer e attendir ed for use	siciar	Part II. Other significant condit	tions contributing to de	eath but not res	sulting in the ur	derlying caus	e given in Part I.	23b. Did to	bacco use cor	ntribute to	the cause of death?		
s, P.O.	requires that the death cert een signed by the attendin hould be detached for use	by Phys	UTI						1 □ Y	es 2 No	3 ☐ Prot	oably 4 ☐ Unknown		
Vital Records,	requir seen s should	Completed by Physician/N							24a. Was a perfor	n autopsy ned?	ava	ere autopsy findings ailable prior to mpletion of cause death?		
al B	sician: The law certificate hes b lirector, page 2 s							174	104	25 WW	1 🗆	Yes 2□ No		
\ Xit	Physician: this certific ral director,	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 No	Hospital:	npatient 2□] ER/Outpatien	t 3□ DOA	Othor: b	eath <i>Check only or</i> Home 5 - Reside		er (Specifi	v)		
ion of	To the Hospital or Attending Physicien: within 24 hours efter death. To the Funeral Director: After this certific: completely filled in by the funeral director.		27. Manner of D th 1X Natural 5 ☐ Pend	28a. Date o	of Injury h, Day Year)	28b. Time of Injury		Injury et Work? 1 Yes 2 No	28d. Describe h			,		
Division	tai or Atters es efter des al Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. Place	of Inju ry - A t h ng, etc. <i>(Specil</i>	iome, farm, stre	et, factory, of	lice .	28f. Location (Si City or Town	reet and Numb n, State)	er or Rura	l Route Number,		
	To the Hospital within 24 hours to the Funeral completely filled	edicai		ring Physiclan: To the al Examiner: On the ba and mann										
	To the within To the compl	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)								Day, Year)				
	10		1/1el	yn U	enu	que	T I	35/4/	-	8 13/	04			
			30. Name and address of perso MVEMURY	900 Completed caus	EDR 6	1 28e) (Type, I	AVE	SILVE	R SP	RING	M	020902		
	Stat	e	31. Date filed (Month, Day, Yea	2004 32. R	egistrar's Signa	ature B	Sport	2						

		-	For Stata Registrar	State of	Maryland / De _l	partment of ertificate of			iene	25100
	hysicia		Decedent's Name (First, Middle, ANNE	Last)		DOYLE		2. Date of Death Month August		3. Time of Death 7:30P. M
	Medic xamin		4a. Facility Name (If not institution,	give street and numb	er)	4b. City, Tow	n, or Location of Dea		4c. County of Death	1
	neral ector		LAUREL REGIONAL 5. Social Security Number 577–18–3469		Age (In yrs. last birthda 83 Yrs.				PRINCE GE Year) 9. Birth Cou 1920 Mary	ORGE'S place (State or Foreign intry) 7land
with the Maryland	te natified at		Usual Residence of Decedent 10a. State 10b. County Maryland Prince	e George's	10c. City, Town or Laurel	Location				10d. Inside City Limits 1 XYes 2 □ No
h with the	st te nuti	al Director	10e. Street and Number 1102 Marton Str	eet		10f. Zip Cod 207		10	Og. Citizen of What Cou United Sta	•
036 urs after death	2	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedor Armed Force d 1 Tyes 2 If Yes, Give Year or Date	es? X INo	I. Was Decedent If Yes, specify C	of Hispanic Origin? (cuban, Mexican, Pue No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - Amer Black, White Specify:	
Maryland 21215-0036 nd 2 should be filed within 72 hours after thand Mental Hygiene.	18	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0.12)	Education grade completed) College (1-4	or 5+) (Gir	edent's Usual Oc re kind of work do DO NOT use re	cupation ne during most of w tired)	orking 1	6b. Kind of Business/li	,
il Hygin	5 6	To Be Co	17. Father's Name (First, Middle, Li Fred	ast)	Fros		18. Mother's Na Mabell	arne (First, Middle, M	faiden Sumame)	nnell
and 2 should be salth and Mental	any injury or other treumatic el		19a. Informant's Name/Relationshi Russell E. Doyl			2 Marton	Street L	aurel, Mar	City or Town, State, Zi Cyland 2070	17
Baltimore, Permit. Pages 1 ar Department of Hea	jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ng,Maryland					
Balti permit. Departr	any in once.		21. Signature of Funeral Service Li	ngera	2	400 POW	ær Mill F	coad Belts	Home, P.A ville, Mary	yland20705
Physi /Med	ician dical		shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. ACL	h line. TE RESPI as a consequence of):					Interval Between Onset and Death
Exan	niner	her	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b. SE	P.515 as a consequence of):					
	burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	RGE BOU as a consequence of):	IEL G	TANGR	ENE		
68760, ficate be ext	the bu	dicai		l SC	HAEHIA					
O et	tached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		n 2 ☐ Fetal death 3 It at time of death 5	☐Ectopic pregna ☐ Other (specify			23d. Date of deliv Month	Pery Day Year
rds, P	be det	by P	Part II. Other significant condition RENAL F	AILURE	<u>=</u> .		given in Part I.	23e. Did toba	acco use contribute to t	
	úσ	Completed	HEPATI	C DYS	FUNCTI	N		24a. Was an autopsy perform	ed? prior to co	opsy findings available ompletion of cause of
of Vital F Physicien: Th	0 = 0	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	atient 2 ☐ ER/Outpati	ent 3 DOA		eath (Check only one) nce 6 □Other (Speci	fv)
ding	funeral	H	27. Manner of _eath 1 X Natural 5 Pending 2 Accident investiga	28a. Date of (Month,		of 28c. Ir	njury at Work? Yes 2 No	28d. Describe how		,,,
Division To the Hospitel or Attending within 24 hours after death.	completely filled in by the	Certification:	3 Suicide 6 Could no determin	ed 289. Place of building	Injury - At home, farm, s , etc. (Specify)			City or Town,		
ne Hosp 124 hou	oletely fi	edical	29a. Certifier (Check only one) Certifying Certifying Certifying Certifying	Physician: To the bas caminer: On the bas and manne	est of my knowledge, de is of examination and/or stated.	ath occurred at the investigation, in m	e time, date and plac y opinion, death occ	e, and due to the cau curred at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	comp		29b. Signature and title of certifier	1 Dans	2		ense number		d. Date signed (Month, August 3, 2	
>			30. Name and address of person w Asif Qadri, M.D.	4700 Ber	of death (Item 23a) (Type wyn House R	a. , Print) d. , #100	College 1	Park, Mary	land 20740	
B	Stat egistra	te	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	Some				

1,72		•	Tor Unpend Item #23a,pt.11,23b,27 per me G834 8/17/0 1- State Registra MEND#15,16a Sb,18 per INF8/5/04, By We Gertificate of Death	dental Hygid 4 tas	ene g. N. 254.09
			Decedent's Name (First, Middle, Last)	2. Date of Death Month	
	Physici /Media		Susan J. Enman	July 29	**
	Examir	46	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
			Union Memorial Hospital Baltimore		
3	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9. Birthplace (State or Foreign Country)
-	Director		213-48-5701 54 Yrs.	July 15,	1950 Washington, DC
	pur 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	anyla ehov	٦			1 Q Yes 2 □ No
	ith tha Marylar or 28e-f ehow	ecto	Maryland Baltimore 10e. Street and Number 10f. Zip Code	10	g. Citizen of What Country?
	vith ti	Funeral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of what Country?
	s 23e	rai	720 East 35th Street 21218	posity Voc or No	USA 14. Race - American Indian,
	er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was pecify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
36	', or	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No If Yes, Give 1 □ Yes 2 ☑ No Specify: Year or Dates:		Specify:
215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow te Madical Examitter riset be rediffied at	edt	15 Decedent's Education 16a. Decedent's Usual Occupation	10	White 6b. Kind of Business/Industry
15	in 72 "ne Padic	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	king	Department Store
212	filed with Hygiene. ther than	E O	Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Nover Worked	-	N/A
	should ba filed within of Mental Hygiene. marked other than imatic event, It a Mental Mental matter and the mat	O	17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Ma	aiden Sumame)
lan	ould ba Mental arked o	To B		Sara Schy Schveon	CON
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene. Item 27 is marked other than "netural", or Itams 23e or 28e-1 ehov other treumatic event, It's Madical Examiter: "und be rediffied at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rut	,	City or Town, State, Zip Code)
Ž	nd 2 s lith ar 27 is r treu		Marion S. Lefkowitz Mother 3509 Randolph Road, Si	lver Spri	no Maryland 20902
ē,	os 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Town, State
JIO	\$ = 50 B		1 Burial 2 Cremation 3 Hemoval from State Norheck Memorial	2 2004 0	7
Baltimore,	orter injur		21 Signature of Funeral Service Licensee 22 Name and Address of Facility		lney,Maryland
B	permit. Pages 1 Department of H Importent: If ite eny injuryer of		Francis J. Collins 500 University Blvd	Funeral H	lome. Inc.
			23a. Part 1, anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac		
4	Dhusisian		shock, & heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Hypertensive Atherosclerotic Cardi	omagulo:	Onset and Death
	Physician /Medical		disease or condition resulting in death) Type: Cettistive Attractories (all the control of the	LOVASCULA	i. Disease
	Examiner				
	41	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
o,	death certificate be executed e attending physician and of for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):		
760	te be ysicia ie bu	icai			
68	tifica ig ph as th				
Box	h cer endir	N/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delivery
	0 0	icia	in the past 12 months? 1 Yes 2 No 9 Unknown		Month Day Year
P.0	that the death ned by the atter detached for u	Physician/Med	9 Unknown		
	requires that the leen signed by th hould be detache	by F	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?
ğ	v require been si	ed	Chronic Obstructive Pulmonary Disease	1 🗆 Yes	2 No 3 Probably 4 Dunknown
Records,		Completed	End State Renal Disease	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	9 4 9	E O	Seizure Disorder	performe	ed? death? ¶No 1 □ Yes 2 □ No
Vital	iclen: Th certificate rector, pag	Be C	25. Was case referred to medical 26. Place of Deat	th (Check only one)	
>	Physicien: this certific ral director,	To E	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residen	ce 6 ☐ Other (Specify)
l of	ding Physicien: After this certific funeral director,		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of 28c. Injury at Work?	28d. Describe how	injury occurred
io	Attending or death. ector: After by the fune	atic	2 Accident investigation M 1 Yes 2 No		
Division	r Atte er de recto by th	tiflo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: All completely filled in by the fu	Certification:			
	Hospital 24 hours a Funerel I	cai	29a. Certifier (Check only (C		
	the H hin 24 the Fi nplete	ledical	one) and manner stated.		
	To t To t	Σ	29b. Signature and title of certifier 29c. License number OCME		I. Date signed (Month, Day, Year) July 30, 2004
	2		Daroe Hallan nd ocme		July 30, 2004
			30. Name and address of person who completed cause of death (Item 23a) Type, Print) 111 Penn Street	- Ral+im	ore, Maryland 21201
_			CIRCL TITICATION THAT	-, патглік	ore, maratam sisai
	Sta		31. Date filed (Month, Day, Year) AUG 0 3 2004 32 Registrar's Signature		
	Registi	ar	AUG 0 3 2004 Souls		

			For State Registrar	State of M	Maryland / [irtment of tificate o				giene Nog. No		
			1. Decedent's Name (First, Middle, Li	ast)						2. Date of Dea	ith	Z U U 4	3. Time of Death
è	Physici /Medio		Russell A. Fabr	itz						Month July 2	Da	y Year 2004	8:00 P M
1	Examin		4a. Facility Name (If not institution, gi	ve street and numbe	er)		4b. City, Town	, or Location of	of Death		4c	County of Dea	
		٠,	Washington Adve	ntist Hos	pital			a Park				Montgo	omerv
	Funeral		5. Social Security Number 6. 265-09-0124	Sex 7.7 Nx⊒M 2 □ F	Age (In yrs. last bir	thday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	(rthplace (State or Foreign country)
	Director		Usuel Residence of Decedent	A	89	115.				Sept. 2	9,	1914	Maryland
	ow ow		10a. State 10b. County		10c. City, Tow	n or Loc	cation						10d. Inside City Limits
	Mary Fig.	tor	Maryland Mon	tgomery	Tak	oma	Park						1 ☐ Yes 2 🖾 🗓 No
	h the	Director	10e. Street and Number				10f. Zip Code)		1	l0g. Cit	izen of What C	ountry?
	n 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow splicial Examinar must be notified at		7105 14th Aven	ue			20912	2				USA	
		Funerai	11. Marital Status	12. Was Deceder Armed Force		13. V	Vas Decedent of Yes, specify Cu	f Hispanic Ori	igin? (Spe	cify Yes or No-		14. Race - Am Black, Whi	
36	or It	by Fu	1 Never Married 2 Married	1 XYes 2 If Yes, Give			☐ Yes 2☐XN					Specify:	White
Ş	within 72 hours after ene. than "natural", or Ite	q pe	3 Widowed 4 Divorced	Year or Dates		Daned	aana Harrat Oaa		-				
5	in 72 in na in teatle	Completed	15. Decedent's E (Specify only highest gi	ade completed)		(Give I	ent's Usual Occ kind of work don O NOT use reti	ne durina mos	t of worki	ng	16b. K	ind of Business	s/Industry
7	with iene.	Шо	Elementary/Secondary (0-12)	College (1-4o 2			il Loar	,				Bankino	
9	I Hygi other	Be C	17. Father's Name (First, Middle, Las	t)				T	r's Name	(First, Middle,			
<u>a</u>	Aental Aental rked c	To B	Carl A. Fabritz					Jul	lia C	. Britt	ing	ham	
an	d 2 should be filed within 72 hour in and Mental Hygiene. 7 is marked other than "natural traumatic event, the Medical E		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailin	g Address (Stre	et and Numbe	er or Rura	l Route Number	City o	r Town, State,	Zip Code)
Σ.	and 2 ealth m 27 i		Margaret R. Fabr	itz/ Wife		7105	14th A	Avenue,	Tak	oma Par	k,	MD 2091	.2
aitimore, Maryland 21215-0036	- I = 2'		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [☐Removal from Stat	20b. Place of cemeter	Dispos	sition (Name of latory or other p	lace)		ly 23,	20c. Lo	ocation - City or	Town, State
Ĕ	Pages ment of l ant: If its		*4 □ Donation 5 □ Other (Special			_	Creek Cemetery			004	Wa	shingto	n. DC
Bail	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	neen (22 F	Name and Add	ress of Facilit	lins	Funera	1 н	ome Inc	
	90 E 8 9		Harris &	Cooks		5	00 Univ	ersity	Blv	d. W.,	Sil	ver Spr	ing, MD 2090
	Physician /Medical		23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	line.	of):	VY	ying, such as	Cardiac o	r respiratory arri	est,		Approximate Interval Between Onset and Death
8/60,	death certificate be executed be attending physician and did for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence		2N1A	,					
Õ	entific ding p	Mec	IF FEMALE:	00 - 1/									
O. Box	that the death certific ed by the attending p detached for use as	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death at time of death		Ectopic pregnan Other (specify)	су				23d. Date of de Month	livery Day Year
 T	The law requires that the te has been signed by the age 2 should be detached.	by PI	Part II. Other significant conditions	contributing to death	but not resulting in	the un	derlying cause g	given in Part I.		23e. Did tob	oacco u	se contribute t	o the cause of death?
Ē	w requires been signi should be									1 🗀 Ye	s 2[No 3□P	robably 4 DUnknown
ပ္ပ	s bae	ompleted								24a. Was a	/. n	24b. Were a	utopsy findings available
Ĕ	The lav	E o								autops	ned?	prior to death?	completion of cause of
Vital Records,	(d) 17	e C	25. Was case referred to medical					26 Place	of Death	(Check only on	NO PNO	1 Yes	270No
	Physician: this certific ral director,	To B	examiner?	Hospital: 1	tient 2 ER/Ou	tpatient	3 DOA	lah		ne 5 🗆 Reside		3 □Other (Spe	city)
וס ר	ding Phys th. After this funeral dia		27. Manner of Death Natural 5 Pending	28a. Date of In (Month, D		ime of	28c. Inj			8d. Describe ho			
0	Attending ir death. ector: After by the fune	ertification:	2 Accident investigation	n		,,]Yes 2□N	No				
DIVISION	r Att	ij	3 Suicide 6 Could not be determined	286. Place of I	njury - At home, fa	rm, stre	et, factory, office	9	2	8f. Location (St. City or Town	reet an	d Number or R	ural Route Number,
	urs al	O		į.									
	Host 24 ho Fund tely fi	edicai	(Silver Silv) Z Infedical Exa	hysician: To the bes	or examination and	, death d/or inve	occurred at the estigation, in my	time, date and opinion, deat	d place, a th occurre	nd due to the ca	ause(s) ate and	and manner as	s stated. to the cause(s)
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner	stated.			nse number					
	F3F8		110 an	181	~		250. 2.00	7 21.	αI		1. Dal	e signed (Mont	ii, Doy, Toal)
	1271	-	30 Name and address at access to	completed assess =	death (lion 00-)	Tue- 5	rint)	VY)	1	11	1/	211	24
			30. Name and address of person who	Simple Cause of	3 S / F	туре, Р	Wish	molo	110	Adi	11-	.)	Harry Mall
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	itrar's Signature	P.	1	T	11)	1.101	IV	nrt	110001000
	Registr		1111 26 21	304 1	was for	7	Mount	2/					

Physician /Medical Examiner Tranklin Windsor Freeman, Sr. 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Nursing & Rehalp. Funeral Director Funeral Director S. Social Security Number 578-09-6944 4b. City, Town, or Location of Death Month Day Yeer July 27, 2004 4c. County of Death Montgomery 4c. County of Death Montgomery Funeral Director S. Social Security Number 578-09-6944 Country Month Days Hours Min. Month, Day, Year) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits		•	For State Registrar	State o	f Marylan		rtment o			/lental Hy	giene	006	25411
Exemptor Shady Crove Adventises Nursing & Rehab. Rockville Shady Crove Adventises Shady Crove Adve					n Sr.		-			Month	aath Day		TD M
Social Security Number Social Security Num							4b. City, Tov	vn, or Location	on of Death				
TORSON STATE OF SHARE SHARE STATE ST													
The State 100 Courty 100 Co										(Month, Di	ay, Year)		ountry)
Section Sect	put *				10c Cit	v Town or Lo	cation						10d Inside City Limits
Section Sect	Maryla f eho	ō		mery									1 Tes 2 No
Section Sect	128e-	rect					10f. Zip Co	de			10g. Citiz	en of What C	ountry?
Section Sect	th with	alD	25145 Old Hundre	ed Road			20	0842			U	SA	
23. Part. Enter the dignesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control of the death of the d	urs after dea at', or ttems Examiner ma	þ	1 Never Married 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	rces? 2. ⊠No ⁄e	lf If	Yes, specify	Cuban, Mexi	can, Puerto	ecify Yes or No Rican, etc.)		Black, Wh	ite, etc.
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23. Part. Enter the dignesse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control of the death of the d	permit. Departn Importe any nju		21. Signature of Funeral Service Ligar	see from	do	Fr. 22	Name and A	ddress of Ea	lins l	Funeral	Home	Inc.	MD 3000
Physician Medical Examiner Immediate Cause (Final disease or Condition resulting in ideath) Septiminary Immediate Cause (Final disease or Condition resulting in ideath) Immediate Cause (Final disease or Condition resulting in ideath) Immediate Cause (Final disease	TEST YEAR		23a. Part1. Enter the disease, or com-	plications that of	aused the death							er spri	Approximate
Sequentially list conditions, if any legating to immodiate cause, if any legating in death last immidiate avenue. IF FEMALE			Immediate Cause (Final disease or condition	a	5		S						
The part of the pa			Sequentially list conditions,	b	1	NEU	MON	IA					(DAY
FFEMALE:	uted d ansit	mine	if any, leading to immediate causu. Enter Underlying Cause (Disease or injury	Due to	or as a consequ	uence of):							
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23c. If yes, outcome of death 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If	be			Due to	or as a consequ	uence of):							
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	the death certific y the attending p Iched for use as I	cian/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live b 4□Pregr	inth 2 ∏ Feta ant at time of d	Ideath 3					2		
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	uires that signed b	by	Part II. Other significant conditions of PROSTATE			ulting in the un	derlying caus	e given in Pa	rt I.			3	
25. Was case referred to medical examiner? 25. Was case referred to medical examiner? 26. Place of Death (Check only one)	s beer 2 shou	plete	HYPERTEN	SION								24b. Were a	utopsy findings available
25. Was case referred to medical examiner?	The i	Com	CHRONIC C	BSTRI	CTIVE	= LIAN	VG DI	SEAS	E	perfo	rmed?	death?	
27. Manner of Death 1	cien: ertific	0	25. Was case referred to medical				7		ace of Deat	h (Check only o	one)		
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 July 28, 2004	ng Phye fter this	-	27. Manner of Death 1 Natural 5 Pending	28a. Date (Mon	of Injury	28b. Time of	28c.	Injury at Work?	7				ecify)
D28656 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	el or Atter s after dea al Director ad in by the	Certifica	3 Suicide 6 Could not be	28e. Place	of Injury - At ho ng, etc. (Specif)	ome, farm, stre	et, factory, of	lice				Number or R	ural Route Number,
D28656 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	he Hospii n 24 hour he Funer		(Check openy /2 Medical Exem	niner: On the b	asis of examina	wledge, death tion and/or inv	occurred at the estigation, in a	ne time, date my opinion, d	and place, leath occurr	and due to the red at the time,	cause(s) a date and p	and manner a place, and due	s stated. e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To t Com	Σ	29b. Signature and title of certifier				29c. Li	cense numbe	er		29d. Date	signed (Moni	th, Day, Year)
	6		rawn					28656			Jul	Ly 28,	2004
					-			#208,	Rock	ville,	MD 20	0850	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature Sparks			31. Date filed (Month, Day, Year)	32. F	egistrar's Signa								

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			For State Registrar	State of Maryland /		rtment of He			giene	004	25412
	Dhysisi		Decedent's Name (First, Middle, Last					2. Date of De Month			3. Time of Death
	Physicia /Medic		JEANNE CONRA			45 Oh To				004 County of Deat	00:30 M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or I		1		MONTGOM	
	Funeral		MONTGOMERY GENERAL 5. Social Security Number 6. Se	x 7. Age (In yrs. last I	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			nplace (State or Foreign
L	Director		220 /0 5215	□M 2 M F 94	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da April	20"1/9	910 0	hio
	and ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation					10d. Inside City Limits
	Many Interes	tor	Md. Montgo	mery Silv	ver S	Spring					1 Yes 2 No
	th the	Oirec	10e. Street and Number	•		10f. Zip Code			-	zen of What Co	
	ath wi	rai	2921 North Leisur			1/ 5 1 1 1 1 1 1	20906			nited St	
	ter de Hema	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 18 No		Vas Decedent of His Yes, specify Cuban	panic Origin? (S i, Mexican, Puert	o Rican, etc.)	-	Black, White	
980	ours af		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		☐ Yes 2 M No	Specify:			Specify: W	nite
5	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or ttems 23a or 28a-f show ther then "naturel", or ttems and the recilied at	Completed by	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	lent's Usual Occupat kind of work done du DO NOT use retired)	uring most of wor	king	16b. Kir	nd of Business/	industry
12	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		nemaker			Ov	vn Home	
<u>5</u>	I Hygi other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle			
ylar	Menta Menta arked aric e	ToE	Loren McCormic				Mary	Conr			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if item 27 is marked other then "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Examination at the pages.		19a. Informant's Name/Relationship (T) Theodore T. Freen		9b. Mailir 2921	g Address (Street al N. Leisu)	nd Numberor Ru ne World	Blvd	er, City or #221 .	r Town, State, 2 Silver	r Spring, Md.
	1 and Heaitl		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of	# 7	Date		cation - City or	
ē	Pages or: # of		1 🔀 Burial 2 ☐ Cremation 3 ☐ I 3 ☐ Other (Specify)	demoval from State Dawle		natory`or other place Cemetery		3/04	Roc	ckville	, Md.
Baltimore,	apartm aporta ny inju		21. Signature of Funeral Service Licens	iee 2	22	Name and Address Muriel H	s of Facility Barber	Funera	1 Hon	ne	
	20729	9	Murief H 1	Double		P. O. Bo	ox 5038,	Layton	svill	e, Md.	20882 Approximate
E		00 1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.				or respiratory a	irrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ACUTE MYOCAI		_ INFARCI.	LON				Immediate
1	Examiner		Conventielly list conditions	DIFFUSE ATH		CLEROSIS					
	po iis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (dr as a consequent	o of).						
_	e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence	ce of):						
760,	icate be executed physician and s the burial-transit	calE	l	d							
89	rtificat ng phy as th	edi	IC CENALE.								· · · · · · · · · · · · · · · · · · ·
Вох	death certifica e attending ph id for use as th	lan/h	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel dea		Ectopic pregnancy			2	23d. Date of deli Month	very Day Year
0.	that the death certifical ed by the attending phy detached for use as th	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4⊡Pregnant at time of death 9⊡ Unknown	5 [Other (specify)					
<u>α</u>	s that the ned by the e detache	by Ph	Part II. Other significant conditions co	entributing to death but not resulting	g in the u	nderlying cause give	n in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Vital Records,	w requires t been signe should be	ed b	HYPERTENSION					1 🗆	Yes 2	XNo 3□Pr	obably 4 Unknown
ecc	2 8	Completed						24a. Was	psy	prior to d	topsy findings available completion of cause of
a H	ate pag							1 ☐ Yes	-	death?	2 No
		o Be	25. Was case referred to medical examiner? 1 Yes 27 No	Hospital: 12 Inpatient 2 ER/	Outpatier	t 3 DOA Othe	26. Place of Dea	ath <i>(Check only</i> Iome 5 ☐ Res		6 ∏Other (Spec	cify)
lof	ig Physter this neral di	n: T	27. Manner of Death → Natural 5 □ Pending		b. Time of	-	and the second s	28d. Describe			
Siol	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be				′es 2□No	206 Landina	(C44	d Misminson D	and Courts March St
Division	or Att	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, tarm, str	eet, factory, office		City or To			iral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, deat and/or in	n occurred at the tim vestigation, in my op	e, date and place inion, death occu	a, and due to the arred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 7	Me	29b. Signature and title of certifier			29c. License				e signed (Monti	
	(0		1 / Henr			D 3	5045		JUL Y	29, 20	004
	V	14	30. Name and address of person who				#204	OLNEV	MD	20832	
	Sta	ate.	PHILIP G. HENJUI 31. Date filed (Month, Day, Year)	32. Registrar's Signature		OOD COURT		ULNET,	. טויו	20032	
	Regist			304 General	19	Sparks					

			1 - For Stata Ragistrar	State of M	Maryland		artment of rtificate o			- '	giene	001	251.13
	Physici	an	1. Decedent's Name (First, Middle	a, Last)		-				2. Date of Dea	ath Day	Year ,	3. Time of Death
ļ	/Media	al	SHEFFIELD 4a. Facility Name (If not institution	FARRI			41. Cit. T			August	3	2004	8:03AM
	Examir	er	Doctor's Con			al	4b. City, Town Lanh		or Death			ounty of Death	Georges
	Funeral		5. Social Security Number	6. Sex 7. /	Age (In yrs. Ia		If Under 1 Yea	ar If Under	24 Hrs.	8. Date of Birtl			place (State or Foreign
	Director		092-03-2330 Usual Residence of Decedent	1₹ M 2 □ F	99	Yrs.	Months Day	rs Hours	Min.	8. Date of Birth (Month, Day NOV • 2	,190	4 Vir	gin Islan
	nyland show	_	10a. State 10b. County	_		, Town or Lo							10d. Inside City Limits
	Ba-f s	Director		ce Feorges	5	Bow				· · · · · · · · · · · · · · · · · · ·			1 XYes 2 ☐ No
	with t	ä	10e. Street and Number 928 Lakefro	ant Drive			10f. Zip Code				-	en of What Cou	•
	deeth ms 23	Funeral	11. Marital Status	12 Was Deceder	nt Ever in U.S	5. 13.	Was Decedent of	20721 f Hispanic Ori		cify Yes or No-		U.S.A.	
36	be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "naturel", or Items 23a or 28a-f show event, The Madical Examinar must be mailing at	by Fur	1 Never Married 2 Marr	If Yes, Give			lf Yes, specify Cu 1 ☐ Yes 2 🔁 N			lićan, etc.)		Black, White,	etc. Black
Ö	hour ture!	ed p	3 Widowed 4 Divorced	Year or Dates	:: 	16a Dece	dent's Usual Occ	unation				of Business/In	
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<u>\}</u>	should be nd Mental marked o	P_	Thomas Fari			105 14-10	- Add (Ot	-1		lara 1			
Baltimore, Maryland 21215-0036	C1 00 00		Donald Benner		ı	į.	ng Address <i>(Stree</i> Lakefr						,
ō,	s 1 end f Health Item 27 other ti		20a. Method of Disposition		20b. Pla		sition (Name of natory or other p		Da			ation - City or To	
Ë			1 🔀 Burial 2 🗋 Cremation 1 4 □ Donation 5 □ Other (S)				natory or other p. In Mem		8/6/	2003	Roc	kville	. MD
<u>a</u>	permit. Pag Department Importent: Il any injury o		21. Signature di Mineral Service	_iceheer		22	2. Name and Add	ress of Facilit	y Sno	wden 1	Fune	ral Ho	me, P.A.
1)	207 2 2		Line	N. AL	sua							ille,	MD20850
- }	Physician		23a. Part 1. Enter the disease or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ed the death. line.		er the mode of dy	ying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a conseque	ence of):	m						
	ted issit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseque						1		
o`	ate be executed hysiclen and the burial-transli	Examiner	that initiated events resulting in death) Last	c. 16 C Due to (or a	s a conseque	-	encer						
9/60	ate be nysicle he bur	dical		d									
Õ	ertifica ling ph		IF FEMALE:							<u> </u>			
X Q Q	death certific e attending p id for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3	Ectopic pregnan	ıcy			230	 Date of delive Month 	nry Day Year
j.	the d	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	at time of dea	all+ 5_	Other (specify)						
<u>က်</u>	w requires thet the death certificate be executed been signed by the attending physiclen and should be detached for use as the burial-transit	by	Part II. Othar significant condition	ns contributing to death	but not resul	ting in the u	nderlying cause g	given in Part I.			_		ne cause of death?
0	requi	eted								1 L Ye	9s 2□I	No 3 Prob	ably 4 Minknown
Hecord	e las has	completed								24a. Was a autops perform	n 2 sy ned? 2 No	24b. Were auto prior to cor death? 1 Yes	psy findings available inpletion of cause of 2 No
VItal	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Place	of Death	Check only of			
_	is in	ပ္	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpat			JUDON					Other (Specify	′)
ono	nding Phy th. : After thi e funeral c	ertification:	27. Manner of Death 1 Natural 5 Pending investig			28b. Time of Injury	W	uryat ork? ∐Yes 2 ∐ I		3d. Describe ho	ow injury o	occurred	
DIVISION	or Atte	rtific	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ned 200. Place of It	njury - At hon	ne, farm, str	eet, factory, office	9	28	3f. Location (St City or Town	reet and M	Vumber or Rura	l Route Number,
_	spitel	O	29a. Certifier 1 Certifyin	g Physician: To the bes	t of my know	ledge, death	occurred at the	time, date an	d place, an	nd due to the ca	ause(s) an	nd manner as st	ated
	To the Hospitel or Attending Pr within 24 hours either death. To the Funerel Director: After it completely filled in by the funeral	fedical	one)	xaminer: On the basis and manner s	of examination	on and/or inv	estigation, in my	opinion, deal	th occurred	d at the time, di	ate and pl	ace, and due to	the cause(s)
	o T with	Σ	29b. Signature and title of certifier				29c. Licer	nse number	710	2	9d. Date s	signed (Month, I	Day, Year)
	4	}	30 Name and address of pages	who completed source of	donth (Itam)	22a) (T:	Print)))] /	110		1060	51 4.0	004
			THOMAS HANS.	SON M.J.	575	MAIN	STKEET	. 3017	E 35	1 Lac	PEL,	MDO	20107
	Sta Registr		30. Name and address of person v THOMAS HANS 31. Date filed (Month, Day, Year) AUG 0 6	32. Regis	trar's Signatu	ire &	Space	21					

			For State Registrar	State	of Maryl	_	artment of F				ne 2004	25414
			1. Decedent's Name (First, Midd	le, Last)					2. Date	of Death	Day Year	3. Time of Death
	Physici: /Medic		Carole	V	Fe	eltman		<u>-</u>		30,	2004	4:23 A M
1	Examin		4a. Facility Name (If not institution		number)		4b. City, Town, o		of Death		4c. County of Deal	
	Europal		623 Blossom Dri 5. Social Security Number	.ve 6. Sex	7. Age (In	yrs. last birthday	Rockvil If Under 1 Year	If Under		of Birth	Montgome 9. Bird	Ty hplace (State or Foreign buntry)
	Funeral Director		165-32-8690	1 □ M 2 🔼 F		9 Yrs.	Months Days	Hours		ith, Day, Ye $11 19$		nsylvania
	pug *		Usual Residence of Decedent 10a. State 10b. Count	,	10c	. City, Town or I	ocation					10d. Inside City Limits
	Manyli f sho	ī		tgomery		7,		ockvi	110			1 X Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number	LEGUMELY			10f. Zip Code	OCKVI.	TTC	10g.	Citizen of What Co	ountry?
	23e c	ralD	623 Blossom D	rive				208			United	
	er de a Items	nue	11. Marital Status	Armed	Forces?	in U.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Specify Yes n, Puerto Rican, e	or No- tc.)	14. Race - Ame Black, Whit	
36	urs aft	by F	1 ☐ Never Married 2 📉 Ma 3 ☐ Widowed 4 ☐ Divorce	IT Yes.	s 2 🔀 No Give Dates:		1 ☐ Yes 2X No	Specify:			Specify:	White
21215-0036	4 within 72 hours after death with the Maryland liene r then "neturel", or Items 23e or 28e-f show The Medical Evaninet must be rollified at	Completed	15. Decede	nt's Education est grade complete	d)	16a. Dec	edent's Usual Occup e kind of work done	oation during mos	t of workina	16b	. Kind of Business	
21	within ene. then "	mpie	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	d)				
	Hyg the nt,	e Co	17. Father's Name (First, Middle	Last)	5		Homema		er's Name (First, I	Middle, Maid	Own F	lome
lan	~ - 0 =			Horace W.	Vough	t			ЬA	eline	Wingard	
Maryland	and M	-	19a. Informant's Name/Relation		, oug.		ling Address (Street	and Numbe				Zip Code)
	and 2 eaith m 27		Ronald E. Felt	man/ Husb	and	623	Blossom D	rive :	Rockvill Date			
lore	Hite H		20a. Method of Disposition 1 Burial 2 □ Cremation		III State		position (Name of ematory or other pla	ce)	August 3, 2004		. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic evone.	H	* 4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service		(Cemetery 22. Name and Addre	ss of Facilit	yRobert	Mid A. Pu	ldleburg,I mphrev Fu	Pennsylvania
Ba	Depar Impo eny ir			Weals A	∠ MO	0335 R	ockville, ockville.	Inc. Marv	300 Wes 1and 208	t Mon 50-28	tgomery A	neral Home/ venue
			23a. Part1. Enter the disease, shock, or heart failure. Lis	complications that tonly one cause of	it caused the							Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due	to (or as a cor	sequence of):		- 1100				- 1
		er	Sequentially list conditions, if any, leading to immediate	b	to (or as a cor	sequence of):						
	outed id ansif	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Ś								
ó,	e exec ian an urial-tr	Exe	resulting in death) Last		to (or as a cor	sequence of):						
8760,	icate be executed physician and s the burial-transif	dical		d						· · · · · -		
9 x	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes,	outcome of pre	egnancy					23d. Date of de	livery
. Box	death e atter d for u	iciar	in the past 12 months?	4□Pre	e birth 2 🗍 egnant at time		□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year
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	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transif	by	Part II. Other significant condit	ions contributing to	death but no	t resulting in the	underlying cause giv	ven in Part !	. 23e	. Did tobaco	-1	o the cause of death? robably 4 Unknown
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Re	The lav	omp								autopsy performed Yes 2	prior to death?	completion of cause of
Vital		BeC	25. Was case referred to medic examiner?	al				26. Place	of Death (Check	1	140 12.100	2,200
of V	Physicien: this certific ral director,	은	1 Yes 2 No			2 ER/Outpati	all 30 DOV				6 □Other (Spe	cify)
	ling After une	tion;	27. Manner of Death 1 Natural 5 □ Pend investigation	/1/	te of Injury onth, Day Yea	ar) 28b. Time Injury	Wo	ryat rk?]Yes 2.⊟		scribe how i	njury occurred	
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	To the Hospital or within 24 hours after To the Funeref Dirtonnelely filled in I	edical	29a. Certifier 1 Certify (Check only 2 Medical	I Examiner: On the	the best of my basis of exar anner stated.	knowledge, dea mination and/or	th occurred at the ti nvestigation, in my	me, date an opinion, dea	nd place, and due th occurred at the	to the cause time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
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			30. Name and address of perso	who completed ca	ause of death	0.	Print)	0-1	re #32		1	2004
	Sta	ate	31. Date filed (Month, Day, Yea	7) 32	. Registrar's S		e Milip	NO	re sz	4, (iney, MI	1 1085-5
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			For State Registrar	State of M		/ Depa	artment of h rtificate of	lealth	and Me	ental Hygi		egible.	251.16
ر د ا	Physici /Medic		Decedent's Name (First, Middle, La	Jose		trick	Fincutte			Date of Death Month July 29	Day 20	Year 004	3. Time of Death 7:44 P M
	Examin	er	4a. Facility Name (If not institution, given Suburban Hospital)				4b. City, Town, o		of Death			ounty of Death	
	5		Suburban Hospi 5. Social Security Number 6.5		ge (In yrs. la.	st hirthday)	Bethe If Under 1 Year		r 24 Hrs. g	. Date of Birth	ľ	Montgom	ery place (State or Foreign
\$	Funeral Director			1 X]M 2□F	89	Yrs.	Months Days	Hours	Min.	(Month, Day,	1915	Col	inois
	aryland show	_	10a. State 10b. County Maryland Montgo	morry		Town or Lo							10d. Inside City Limits
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	deeth with the Maryland ms 23a or 28a-f show Erium be notified at	raiD	5620 Alta Vista	· · · · · · · · · · · · · · · · · · ·	-		2081				1	USA	
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and	be filed ital Hygi od other svent, I	0	17. Father's Name (First, Middle, Last					18. Moth	er's Name (First, Middle, M	laiden Su	umame)	
<u>X</u>	Men	은	Joseph John Find						Clara	Lucy F			
Ма	alth and 27 is m		19a. Informant's Name/Relationship (Helen Fincutter	* .			ng Address <i>(Str</i> eet O Alta Vi						
more,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury greether fraumatic evonce.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special		cen	netery, crei Metro <u>r</u>	osition (Name of matory or other plac politan	ce)	Jul Jul	y 31,		tion - City or T	own, Slate Virginia
Baltimol	permit. Departm Importe any inju		21. Signature of Funeral Service Ace	Se and	,	22 Fra	matory 2. Name and Addre rancis J.	Coll	lity	umana 1	T	T	
) I	Physician /Medical Examiner		23a. Part1. Enter the sease, com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that cause one cause on each li a. Due to (or a	no.	cul	20 Univer ter the mode of dying	sity ng, such as	Blvd. s cardiac or r	W. Si	lver	Sprin	MD 2901 Approximate Interval Between onset and Death
08/00,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as C Due to (or as									
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Ma	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatie	- /		oth Oth			Check only one			
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UNISION	Attendii r death. actor: A by the tu	Certification;	2 Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inj	ury - At hom			Yes 2□		Location (Stre	et and N	lumber or Rura	al Route Number,
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	To the Hosp within 24 ho To the Fune completely fi	edicai	29a. Certifier 1 Sertifying Pt (Check only 2 Medical Examone)	nysician: To the best miner: On the basis o and manner sta	t examinatio	edge, death n and/or in	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, and ath occurred	d due to the cau at the time, dat	ise(s) and e and pla	d manner as s ace, and due to	tated. the cause(s)
1	ロナー	Σ	29b. Signatury and title of certifier	lulm			29c. Licens	a number	16	290	Jul	igned (Month,	Day, Year)
(i	0		30. Name of d address of person who	completed cause of d	leath (Item 2	3a) (Type,	Printy B	100	Ro	1.1/2	14	0 2-	852
1	Sta Registr		31. Date filed (Month, Day, Year) AUG 02		ar's Signatur		Sport	61					

			For State	State	of Marylar		ertment of H		nd Mental H	0	001	05116
			Registrar 1. Decedent's Name (First, Middle, L	261)		Cei	unicate or	Deain	2. Date of D	Reg. Nø.	UUU	3. Time of Death
	Physicia /Medic		Alicia	Gin	n						2004 ^{Year}	6:40 am
Ž	Examin		4a. Facility Name (If not institution, g	ive street and n	umber)		4b. City, Town, o			4c.	County of Death	
			Kensington Nur		+		Ker If Under 1 Year	singto		ieth.	Montgom	
ı	Funeral Director		5. Social Security Number 376-32-7887	Sex 1 ☐ M 2 X ☐ F	7. Age (In yrs.	7 Yrs.	Months Days			9, Year)	9. Briting	place (State or Foreign intry) land
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c C	ity, Town or Lo	cation					10d. Inside City Limits
	aryla ehov	7		irfax		cLean	cation					1 ☐ Yes 2 ☐ No
	the M	Director	10e. Street and Number	IIIdx	11	Съеви	10f. Zip Code			10a. Citiz	zen of What Cou	intry?
	with 3a or		1350 Beverly F	load, #7	02		2210)1			USA	,
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other then "neturel", or Items 23a or 28e-f ehow empraint: If item 27 le marked other then "neturel", or Items 23a or 28e-f ehow empraint in the rollified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed F	2 1 No	'	Was Decedent of H f Yes, specify Cub	an, Mexican, I	n? (Specify Yes or N Puerto Rican, etc.)		14. Race - Amer Black, White Specify: Whi	, etc.
ğ	2 hou	ted	15. Decedent's	Education		16a. Dece	tent's Usual Occup	ation	of working	16b. Kir	nd of Business/I	ndustry
215	hin 7.	Completed	(Specify only highest of Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done OO NOT use retire	d) most o	ar working			
2	er the	Con	12			Hon	nemaker	,		<u> </u>	Own Hom	ie
Maryland 21215-003	be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	st)				18. Mother's	s Name (First, Midd	le, <i>Maid</i> en	Sumame)	
Sa	Men Marke Marke	မ	Feliks Mistat	CT Dish		405 14-00			nina_Czaje		- T C4-4- 7	:- O- d-1
Mar	12 sh h and 7 le m treum		19a. Informant's Name/Relationship Harold Stuart		enhew				or Rural Route Num #702, MC	-		
ė,	1 and Healt lem 2		20a. Method of Disposition	<u> </u>	20b	Place of Dispo	sition (Name of		Date	_	cation - City or T	
nor	ages ont of it: If it		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		n State		politan	Ce)	July 23, 2004	77.00		Winesinio
Baltimore,	mit. Partme		21. Signature of Funeral Service Lie		^		matory	ess of Facility	ns Funera			Virginia
ä	Dep Per S		> John E	· (- Fa	Ale							g, MD 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	caused the dea	ath. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a Meta	static	Cervica	1 Carcin	ioma			- 4	Onset and Death 1 year
	/Medical Examiner		resulting in death)		o (or as a conse							
B	LAGIIIIICI	100	Sequentially list conditions,	b. Due to	o (or as a conse	dilence of).						
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,	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a conse	quence of):						
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Q	that the by detail	y Ph	Part II. Other significant condition	contributing to	death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Dio	I tobacco u	se contribute to	the cause of death?
rds,	quires (n signe	d by							1	Yes 2	ONo 3□Pro	bably 4 Unknown
Record	e law requir has been si je 2 should	Completed								s an opsy formed?	24b. Were aut prior to c death?	opsy findings available ompletion of cause of
E E									1 ☐ Yes		1 Yes	2 🗆 No
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ō	⊑ ÷ ⊑	۲۰ : To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date	e of Injury	ER/Outpatier 28b. Time o	28c. Inju	ry at	ing Home 5 Re			ny)
lon	Attending Phir death. ector: After thi	atlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga		onth, Day Year)	Injury		rk?]Yes 2.∏No	0			
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	10		> Brea	osex	Calla		р09	834			July 2	3, 2004
			30. Name and address of person will Barry Rosenbar					e. Kens	ington, M	ID 208		
	Sta	ate	31. Date filed (Month, Day, Year)	32	Registrar's Sign	acture :	A					
Ł	Regist		JUL 26 21	104 0	sera	1	Sporks					

			1 - For Stata Registrar		State of M	aryla	nd / Dep	artme		ealth ar		-	0001	25417
	Physici		Decedent's Name (First, Midd: MARVIN	e, Last)	G	OTTL	TEB				2. Dat Mo JUI		Day Year 2004	
	/Medi Examir		4a. Facility Name (If not institutio	n, give s			100	4b. C	ty, Town, or	Location of I		و 20 اد	4c. County of De	6:25 A M
			HEBREW HOME OF	GRE	ATER WAS	HING	TON	RO	CKVILI	ĿE		1	MONTGOME	RY
	Funeral Director		5. Social Security Number 116-14-5881	6. Sex	7. A		. last birthday 79 Yrs.	Month	der 1 Year Is Days	if Under 24 Hours	Min. (Mo	e of Birth onth, Day, Ye	9. B 1924 NEW	rthplace (State or Foreign Country) YORK
	land		Usual Residence of Decedent 10a. State 10b. County			10c. C	ity, Town or I	Location						10d. Inside City Limits
	the Mary 28e-f shi	Funeral Director	MARYLAND MONTGO	MER	Y	RO	CKVILL		**- O- 4-			1.2		1 X Yes 2 □ No
	with with	בֿ	6111 MONTROSE I	TA O	л тогг О	04			Zip Code 0852				Citizen of What C	country?
	death ms 2;	era	11. Marital Status	_	2. Was Decedent	Ever in t	J.S. 13			spanic Origin	n? (Specify Ye Puerto Rican, e		14. Race - Am	erican Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or Items 23a or 28e-1 show event, the Modical Exerting martines recilified at	ē	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced		Armed Forces? 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:				ecify Cuba 2⊠ No		Puerto Rican, e	etc.)	Specify: W	ite, etc. HITE
5-0	72 hc	etec	15. Deceder (Specify only highe	t's Educ st grade	ation completed)		16a. Dec	edent's U	sual Occupa	ition luring most o	f workina	16b	. Kind of Busines	s/Industry
121	within han han	Completed	Elementary/Secondary (0-12)	Ť	College (1-4or	5+)	life.	DO NO	use retired				GARMENT	
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an	should be fited and Mental Hygin marked other imatic event, ii	To Be	AARON		GOTT	LTER					ritatile (1 ii si,			
Maryland	s 1 and 2 should it Health and Men item 27 is marke other traumatic	۴	19a. Informant's Name/Relations	hip (Typ		ענידנינ	19b. Mai	ling Addre	ss (Street a	ROSE	or Rural Route		FRIEDMAN by or Town, State,	Zip Code)
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ore,	es 1 au of Hea litem rothe		20a. Method of Disposition	2 O D		20b.	Place of Disp	osition (A	ame of	e)	Date	20c.	Location - City o	r Town, State
Ē	Pages nent of I ant: If it		1 XBurial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		emoval from State	i	DEAN M	-			7/30/20	04 01	LNEY, MAI	RYLAND
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service	License	Me 1	eme	es E	22. Name DWAR 091	and Addres D SAGI ROCKV	s of Facility EL FUN	ERAL DI	LRECTION OF THE PROPERTY OF TH	ON, INC. LE, MD 2	0852
	eath certificate be executed EX attending physician and for use as the burial-transit	ical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6.	Due to (or as CARDIAC Due to (or as HYPERTE Due to (or as	FAI a consecutive of the consecu	Quence of): LURE Quence of): N	ESS						UNKNOWN
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	uires tha signed Id be dei	þ	Part II. Other significant condition ATRIAL		ributing to death b		sulting in the	underlying	cause give	n in Part I.	23e			o the cause of death?
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Zi:	Physicien: 1 this certifical ral director, p	Be	25. Was case referred to medica examiner?	-	ospital:				Othe		Death (Check			
		. To	1 ☐ Yes 2 X No 27. Manner of Death		1 ☐ Inpatie		28b. Time of		JOA _	4 IXI NUISI			6 □Other (Spe	cify)
o	ding f th. : After s funer	tio	1 Natural 5 ☐ Pendin 2 ☐ Accident investi		(Month, Da	y Year)	Injury	М	28c. Injury Work	es 2 □ No	200.000	301.00 11017 111	july occurred	
-	of or Attending safter death. I Director: After d in by the fune	ertification	3 Suicide 6 Could determ	not be	28e. Place of Inj building, et	ury - At h c. (Speci	ome, farm, st fy)	reet, facto	ry, office			ation (Street or Town, Sta		ural Route Number,
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	To the within 2 To the I complet	Me	29b. Signature and title of certifie					2	9c. License	number		29d. C	Date signed (Mont	h, Day, Year)
	6		> Suepule						D0002	2713		JUI	LY 28, 20	004
			30. Name and address of person					,						
			SHILPA AMIN, M	.D.,				AD, R	OCKVI	LLE, M	ARYLANI	D 2085	2	
	Sta Registr		31. Date filed (Month, Day, Year)	2004	32. Registr	_	Sture	Sp	aks	,				

		State of Maryland / Depart			•	•	
		Registrar CETU	ficate of	Death	R	eg. Ng. 0 0 L	25418
Physicia	n	1. Decedent's Name (First, Middle, Last)			Date of Dea Month	Day Year	3. Time of Death
/Medic	al	Frederick L. Grant	. O. T.		July 20		2:39 P M
Examine	er	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	_	r Location of Death		4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clintor	If Under 24 Hrs.	8. Date of Birth	Prince G	tholace (State or Foreign
Director		083-12-5827 83 Yrs.	Months Days	Hours Min.	(Month, Day, Dec. 20	, 1920 Ne	w York
and		Usual Residence of Decedent 10c. City, Town or Locat 10a. State 10b. County 10c. City, Town or Locat	tion				10d. Inside City Limits
Marylan -f show	ţ	Maryland Prince George's Upper Marl	lboro				1 ☐ Yes 2X No
h the	Director		10f. Zip Code		1	0g. Citizen of What Co	ountry?
:1215-0036 within 72 hours after death with the Maryland ene. then "natural; or items 23e or 28e-1 show the Madical Examiner must be notified at		8907 Fairhaven Ave.	20772			U.S.A.	
ar dea	Funerai		s Decedent of H es, specify Cuba	ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
336 irs after	by F	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? WWII I XYes 2 Nec 1942 1 Was Give Year or Dates: O Oct 1953	Yes 2XNo	Specify:		Specify:	White
21215-0036 d within 72 hours attgene. Then "netural; or the Medical Exami	ted		it's Usual Occup	ation		16b. Kind of Business	
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121 ted w lygien ther th		12 Airlin	ie Capta			Airlin	es
anc ancal H and H ed of	Be	17. Father's Name (First, Middle, Last) Frederick L. Grant		18. Mother's Name Mildred			
Maryland d 2 should be file th and Mental Hy 27 is marked oth traumatic event	ဥ		Address (Street			City or Town, State, 2	Zip Code)
						rlboro, MD	
or He rother		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State				20c. Location - City or	
Fag Pag University	74	`4 □ Donation 5 □ Other (Specify) Metropolit	an Crem	atory 7/2	22/04	Alexandr	ia, VA
Baltimore, oermit. Pages 1 ar Department of Hear mportant: If litem: any injury or other page.	Ц		ame and Addres	ss of Facility Ociety, In	nc.		
				rdale, FL		net	Approximate
72.5		23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line. Immediate Cause (Final		9, 5001 05 0010100 01	roopiiatory arre	330,	Interval Between Onset and Death
Fnysician / /Medical		disease or condition resulting in death) a. Uro So Sis Due to (or as consequence of):					5 days
Examiner		Sometially list applified h	ewt D	seure			
Do ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter thidentying Cause (Disease or injury that artisted exert in the conditions)					
60, be executed sician and burial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of):					
760, te be ex ysician a	cai E	33.4 (33.5.6)					
Box 6876 Box etalicate be attending physic	edic	0.					
Nox lox th cert th cert is and in	an/M	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3☐Ec	topic pregnancy			23d. Date of del	
O. E. e dea the att	Physician/Medi		ther (specify)			Month	Day Year
P.O. that the de detached		Part II. Other significant conditions contributing to death but not resulting in the unde	irlying cause give	en in Part I	23e Did tob	acco use contribute to	the cause of death?
Se ged	d by		mying oddso give	on in a care i.	1 🗆 Ye		obably 4 □Unknown
Cord w require	ompleted				24a. Was ar	24b. Were au	topsy findings available
Rec The taw te has age 2 s	omp				autops: perform	y prior to death?	completion of cause of
ital	BeC	25. Was case referred to medical examiner?		26. Place of Death (1 ☐ Yes 2 Check only one		2 No
hysic or his or	2	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA Othe	4 Nursing Home	5 Reside	nce 6 □Other (Spec	rify)
On on of other throng the funeral	ion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury Work	/ at 28 (? // es 2 □ No	d. Oescribe ho	w injury occurred	
Division Division or Attending after death. Director: After	ficat	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street,			f. Location (Str	reet and Number or Ru	ral Route Number.
Div	Certification;	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town	, State)	
	ledicai (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death or 2 Medicel Exeminer: On the basis of examination and/or invest and manner stated.	curred at the time tigation, in my op	e, date and place, an pinion, death occurred	d due to the ca l at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
To the mithln ro the comple	Mec		29c. License	number	29	d. Date signed (Month	. Day, Year)
Jul -		Walin J. Jamen	D35	206		Inly 20, 2))
- (7		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin W: Ilium T. TANKET M7 11701 UVING it 31. Date filed (Month, Day, Year) JUL 27 2004	nt)	C	- 1	to -11.	. 1 .
Stat	9	William T. TANNER My 11701 Living it 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	M EVAC	1 th #101	mrw	AZHIN (M) IN	my mc
Registra	-	JUL 27 2004 Spread B	sporks	/			

n			State of Maryland / Department of Health and M	Mental Hygi	ene							
			Registrar Certificate of Death		g. N6)	251.10						
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death						
ine	/Medic		Arthur Joseph Green	July	21 2004	1:06 A M						
سم	" Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death							
			Doctors Community Hospital Lanham		Prince G							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	lace (State or Foreign try)						
	Director		229-34-6331 TIME 2 F 70 Yrs. William 2 F 70 Yrs.	Apr 23,	1934 Wash	. D.C.						
	land w		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits						
	Mary f sh	ō	Maryland Prince George's Bowie			1X Yes 2 □ No						
	r 28a	rec	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Coun	itry?						
	h with	DIE	4316 Saddle River 20720		United Stat	es						
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 10.52 13. Was Decedent of Hispanic Origin? (Sp. 10.52) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Americ							
9	after or Ite	교	1 □ Never Married 210 Married 110 Yes 2 □ No 1953 -	nican, etc.)	Black, White,	etc. .ack						
8	urat',	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1955 1 ☐ Yes 2 ☒ No Specify:		Specify: B.L.	ack						
21215-0036	within 72 hours after death with the Maryland ene. then "neturet", or Items 23e or 28e-f show Its Medical Eracinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	king 1	6b. Kind of Business/Inc	lustry						
12	withir	m d	Elementary/Secondary (0-12) College (1-4or 5+) 4 Building & Grounds Ins	nector	Federal Gov	vernment						
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Maryland	ad be intal i	Be c	Arthur J. Green Gladys		alden Sumame,							
2	hould Me mark matik	ဌ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		City or Town State Zin	Code						
<u>≅</u>	id 2 s ith ar 27 is treu		Luella Green (wife) 4316 Saddle River, Bo		20720	0000)						
ō,	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other then "naturat", or Items 23e or 28a-f show other treumatic event, the Medical Expringer must be notified at		20a Method of Disposition 20b, Place of Disposition (Name of		20c. Location - City or To	wn, State						
2	O vi II		1 _Buriai 2 _Cremation 3 _Removal from State 1 _Donation 5 _Other (Specify) Cheltenham Cemetery 7-	27 04 -		_						
altimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot		'4 □ Donation 5 □ Other (Specify) Cheltenham Cemetery 7- 21. Signatur, Funeral Service Licensee 22. Name and Address of Facility McGi	uire Fune	heltenham eral Service	Maryland						
ä	Per Per Per Per Per Per Per Per Per Per		Seny D. of these 7400 Georgia Ave. 1									
	_		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arres	st, disson	Approximate Interval Between						
4	Physician		Immediate Cause (Final disease or condition resulting in death) a. h. worthouse of the condition resulting in death)	1 1	CS. 105	Onset and Death						
*	/Medical		resulting in death) Que to (or as a consequence of):	- Cosario	VILLECCE							
	Examiner		Sequentially list conditions, b.									
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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8760,	cate be execut ohysician and the burial-trar	Ē	Due to (or as a consequence of):									
87	physi the b	dicai	d.									
9 ×	death certific e attending p ed for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		004 004 44 5							
Вох	atten for u	cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliver Month	ry Day Year						
O.	the d y the iched	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown									
σ	es that thighed by be detact	by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?						
Records,	requires that been signed b hould be deta	q p		1 ☐ Yes	s 2□No 3□Proba	ably 4 Unknown						
00		Completed		24a. Was an	24b. Were autor	osy findings available						
Be	Φ - - - - - - - - - -	mo		autopsy	ed? death?	npletion of cause of						
Vital	ilcien: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of Deat	th (Check only one		2 No						
<u>></u>	Physicien: this certific ral director.	To B	examiner?		nce 6 Other (Specify)						
J Of	ding Phys T. After this funeral di		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how								
ior	Attending ir death. ector: Afte by the fune	atio	2 Accident investigation M 1 Yes 2 No									
Division	r Atte	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree	eet and Number or Rural State)	Route Number,						
	Itel or aff	O										
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cau	use(s) and manner as state and place, and due to	ited. the cause(s)						
	thin 2 the mplet	Med	one) X and manner stated. 29b. Signates and title of certifier 29c. License number		d. Date signed (Month, D							
			12/0									
	104,		30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)	Jı	uly 21, 2004	1						
			Tateica Aronica - Kilak wall Penn Street, Bal	timore M	Marvland 21	201						
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		LUYTURE 21	-O1						
	Regist	ar	JUL 26 2004 Store 19 sports									

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 28, ^D2004 Year **Physician** Jai Gupta 6:30 A M Bhagwan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Home Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 76 579-62-5205 Director June 4, 1928 India Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State *Poy 10d. Inside City Limits r 28a-f shov 1 ☐ Yes 2 ☑ No Maryland Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be 5914 Lone Oak Drive 238 20814 India Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status the Medical Examiner Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2K Marned 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No δ Specify: 3 Widowed 4 Divorced Asian Indian natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) International then Elementary/Secondary (0-12) College (1-4or 5+) Monetary 5+ Director of Statistics permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygie
Important: if Item 27 is marked other t
any infury or other traumatic event, in
porce. Fund other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Atma Ram Gupta Kamla Devi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashok Gupta/ Son 708 Greenwich Street, #3-F, New York, NY 10014 20b. Place of Disposition (Name of carpetery, crematory or other place)
Montgomery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. July 30, 2004 Bethesda, Mayrland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licer MQ0689 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 23a. Hart1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician <u>Cardiac Arrest</u> 1 hour resulting in death) /Medical Due to (or as a consequence of): Examiner Cardiac Arrhythmia 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit Cardiomyopathy 10 years resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy اور in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I by the a ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 € No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nulli Duyun D37840 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brent A. Berger, M.D. 10215 Fernwood Road, #100, Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylan	-	artment of F			iene	251.21
	Physici		Decedent's Name (First, Middle, Last) FLORENCE	W.	GAITH	IER		2. Date of Dear Month Aug •		3. Time of Death 2:45A M
): 	/Medic Examin		4a. Facility Name (If not institution, give st. Casey House	reet and number)		4b. City, Town, o	r Location of Death		4c. County of Death MONTGOM	
	Funeral Director		213 40 0070	7. Age (In yrs. 77	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) June		ace (State or Foreign try) ryland
	Maryland If show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgome		y, Town or Lo Rock	cation ville			11	0d. Inside City Limits 1 ∰Yes 2 □ No
	th with the 23s or 28	Funeral Director	10e. Street and Number 5309 Crestedge	Lane		10f. Zip Code 208	353	1	0g. Citizen of What Coun	try?
900	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Madical Exeminar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, o Specify: B1	
Maryland 21215-0036		Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	lent's Usual Occup kind of work done DO NOT use retired COSSING	during most of work d)	ting	Montgome Polic De	ry Co.
yland	2 should be filed and Mental Hygie le marked other sumatic event, III.	To Be (17. Father's Name (First, Middle, Last) William Winde					raska	Carroll	
Mar	s 1 and 2 should if Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type Regina Gaither-e		1				, City or Town, State, Zip kville, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 le any injury or other trai		20a. Method of Disposition 1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	Place of Dispo	sition (Name of natory or other place on Mem	ce)	Date	20c. Location - City or To	wn, State
Balti	permit. Departm Importe any inju	-	21. Signature of Funeral Service License		22	. Name and Addre	ss of FacilitySnc	wden F	uneral Hom	e P.A.
	Physician	į į	shock, or heart failure List only one Immediate Cause (Final disease or condition	cause on each line.					est,	Approximate Interval Between Onset and Death Year
8760,	/Medical Examiner bhysicien and the burial-transit	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
O. Box 6	death certifi e attending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2₹ No 9 □ Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of deliver Month	y Day Year
rds, P.	n requires that the been signed by th should be detache	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		pacco use contribute to the	e cause of death?
Vital Record	The law ate has b page 2 s	Completed						24a. Was a autops perform 1 Yes 2	24b. Were autop prior to con death?	sy findings available pletion of cause of
f Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital:	ER/Outpatien	t 3 DOA Oth	er: 4 Nursing Ho		e) ince 6 ^{XE} Other (<i>Specify</i> ,	Hospice
sion of	ling After une		27. Manner of Death ↑★ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe ho	w injury occurred	
Division	of the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the control of	y)			City or Town		
	To the Hospital of within 24 hours elected To the Funerel Decompletely filled i	edical	29a. Certifier (Check only one) Certifying Physi 2 Medical Exemine	cien: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred at the tire restigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	tuse(s) and manner as sta ate and place, and due to	ited. the cause(s)
	i	Me	29b. Signature and title of contifier	- mo		29c. Licens D3	e number 5635		ed. Date signed (Month, Date Signed (Month) (Month, Date Signed (Month) (Month, Date Signed (Month) (Month	
	13		30. Name and address of person who com				Mill Rd	Rockwi	lle, MD 20	855
	Sta Registi		MR. Joseph Kapl 31. Date filed (Month, Day, Year) AUG 0 6 200	32. Registrar's Signa	iture &	Sparks		110011 V I		

			For State	State of Maryland	d / Depa	artment of H	leaith and M	•	•				
			Registrar	· · · · · · · · · · · · · · · · · · ·	Ce	rtificate of	Death		leg. No.	25422			
	Physici	ian	Decedent's Name (First, Middle, Last)					Date of Dea Month	ith Day Year	3. Time of Death			
	/Medi		Pearlie M. Ga					0.8	01 2004	4:50a [™]			
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			Washington Adv				na Park		Montgo	omery			
	Funeral Director		311-34-0040	7. Age (In yrs. la M 2頃F 65	est birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 06/20	7, Year) 9. Bir 739 Va	thplace (State or Foreign puntry)			
	pus A]	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	ocation				10d. Inside City Limits			
	e Maryla Ba-f sho	ctor	Md Montgo			Spring				1 ☐Ves 2 No			
	th with th 23a or 26 set be no	Funeral Director	10e. Street and Number 1110 Chickasaw	Drive		10f. Zip Code 209 ()3		10g. Citizen of What Co USA	ountry?			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	0	te, etc.			
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Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		1 Burial 2 ☐ Cremation 3 ☐ R	dinoval ildin otate		osition (Name of matory or other place	10016						
ŧ	permit. Page Department o Important: If any injury or once.		'4 □Donation 5 □Other (Specify)	Ga	tes (of Heave	211			spring,Md			
Bal	permit. Departr Importa any inj		21. Signature of Funeral Service License	90	2:	2. Sime and Addra Spead F	uneral	Home &	Crematic	on Service			
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Box 68760,	The law requires that the death certificate be executed title has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar	death 3[⊒Ectopic pregnancy		23d. Date of del	23d. Date of delivery				
Ö	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at time of de 9⊡ Unknown	ath 5[Other (specify)			Widilli	Day Year			
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of	hysic his co	P	1 □ Yes 2 No		R/Outpatie	nt 3 DOA Oth	er: 4 Nursing Hor	me 5 🗆 Resid	ence 6 □Other (Spe	cify)			
ion o	utending P death. ctor: After to the funera	ation:	27. Marher of D. ath 11 Natural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred				
Division	tal or Atters as after de al Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (City or To						treet and Number or Ru n, State)	ıral Route Number,			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	vledge, deat ion and/or in	h occurred at the tin vestigation, in my o	ne, date and place, a pinion, death occurre	and due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)			
	To the vithii To the comp	M	29b. Signature and title of certifies	1 . 2 0		29c. Licens	e number	2	29d. Date signed (Monta	h, Day, Year)			
	/		1/19	VIL		1	454	71	8/11/1	21 1			
	>		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print)		1-1-	-/1/	7			
	-01		31, Date filed (Month, Day, Year)	32. Registrar's Signat	Ė	1	Min	5 ton	AUB A	Hot Hosp			
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			Decedent's Name (First, Middle, Last)						2. Date of Death	g. reg.	3. Time of Death			
П	Physici: /Medic		Theo Fave Coodman											
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of		ury 27	29, 2004 10:30 P				
			Brooke Grove Nursing	g Home		Olney				Montgor	nerv			
	, Funeral .		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)			
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	land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits			
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8	within 72 hours after death with the Maryland ene. than "natural", or Hems 23a or 28e-f show the Medical Examiror mant be multired at	ed b	15. Decedent's Educatio											
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ylaı	Ments Ments arked atic e	To	Joseph Lenard Neves				Magg	ie Cl	ifford					
lar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ite Medical Examitive mat be multived at once.		19a. Informant's Name/Relationship (Type, F	Print)	19b. Mailin	g Address (Street a	nd Numbe	er or Rural F	Route Number,	City or Town, State,	Zip Code)			
Baltimore, Maryland 21215-0036	l and Health em 27 har t		Charles Goodman- Hus 20a. Method of Disposition	band	12606	Goodh111	Rd.	Silve		g, MD 209				
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			23a. Part1. Enter the disease, or complication	ns that caused the death										
			shock, or heart failure. List only one ca Immediate Cause (Final	oophatory arros		Approximate Interval Between Onset and Death								
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87	icate be executed physician and s the burial-transit	dical	d											
× 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c, If	yes, outcome of pregna	ncv						1			
Вох	death atter	ciar	in the past 12 months?	☐Live birth 2 ☐Fetal ☐Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	Day Year			
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	es that igned to be det	by P	Part II. Other significant conditions contribu	ting to death but not resu	ulting in the un	iderlying cause give	n in Part I.		23e. Did toba	cco use contribute	to the cause of death?			
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	The laste has page	Completed							autopsy performe 1 ☐ Yes 21		completion of cause of			
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place	of Death (C	Check only one)					
<u></u>	Attending Physician: or death, actor: After this certifica by the funeral director, p	2	1 ☐ Yes 2X No	1 ☐ Inpatient 2 ☐ I	· ·		4 LA INUI			ce 6 □Other (Spe	ecify)			
UC.	ling F	ion		a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			I. Describe how	injury occurred				
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is in the leaf of										se(s) and manner a	s stated.			
	n 24 t	Medicai	(Check only Z Medical Examiner: (On the basis of examinati nd manner stated.	ion and/or inv	estigation, in my opi	nion, deat	h occurred	at the time, date	and place, and du	e to the cause(s)			
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. License	number		29d	. Date signed (Mon	th, Day, Year)			
	5	D18726 August 2, 2004								2004				
			30. Name and address of puson who comple											
			Arthur Schoengold, 1	1/		Phillip :	Dr. C	lney,	MD 208	32				
	20.0	te	31. Date filed (Month, Day, Year) AUG 0 6 2004	32. Registrar's Signat	ure £	Spark								

State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amend Item 10b per FH, G834, 08/26/00/60/10/10/10 Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** August 1, 8:58 A Basanti Gope /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month. Day, Year) | April 1, 1946 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F India 213-47-8489 58 Yrs Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Mudical Examinar must be notified at agree. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Prince George's 1 Yes 2 No Completed by Funeral Director Maryland Beltsville 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 20705 USA 4701 Montgomery Place 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Asian 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Healthcare Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mariam Kujur Ohma Ekka ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bhagirathi Gope- Husband 4701 Montgomery Place Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cem 08/04/04 Adelphi, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 proba 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 Years Metastatic Endometrial Cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the about the control of the control o as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 X Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 1 Tyes 2 No 1 ☐ Yes 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No м n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0041119 Aug 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daya S. Sharma, M.D. 50 West Edmonston Rd. Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 0 4 2004 Registrar

			For State Registrar	State of Marylan	d / Depa		lealth and		2111		
			Decedent's Name (First, Middle, Last)		timouto or i	Jean	2. Date of De	110 g. 110.	3. Time of Death	
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	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea		30, 2004 4c. County of D	9:30 A M	
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	Director		348-12-2598 ^{1X}	IM 2□F	86 Yrs.	Months Days	Hours Mir	n. (Month, Da	y, Year)	Birthplace (State or Foreign Country)	
b	ט		Usual Residence of Decedent					Dec. 1	4, 1917 I	llinois	
	nylan how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits	
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1	p.2		shock or heart failure. List only of	ne cause on each line.	n. Do not ent	er the mode of dying	g, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
5.0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Prostate Car	icer					Onsot and Doctin	
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Ì	140		30. Name and address of person who co	impleted cause of don't /tra-	23a) /T	D O	25364	ט	8/2/04		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dey Month Physician AUGUST MILTON LEON GREENBERG, SR. 2004 9:56 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SURBURBAN HOSPITAL BETHESDA 5. Social Security Number If Under 1 Year tf Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JUNE 2, 19 Birthptece (State or Foreign Country) NEW YORK 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F 90 104-07-3037 1914 Director Usual Residence of Decedent 10d. tnside City Limits 10a. State 10b. County 10c. City. Town or Location nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar sarment of Health and Mental Hygiene. ortains: if item 27 is marked other than "natural", or itema 23s or 28s-1 show injury or other traumatic avant, the Medical Examiner mast by inclined as 1. 1 GYes 2 □ No Director ROCKVILLE MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 UNITED STATES 1515 DUNSTER ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🗓 No Specify: Specify 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GROCERY STORE SUPERVISOR 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be **ETTA** RUBENS GREENBERG SOL ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1609 FARRAGUT AVENUE, ROCKVILLE, MD MILTON L. GREENBERG, JR., SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Oremation 3 ☑ Removal from State 4 ☐ Dogration 5 ☐ Other (Specify) permit. Page Department of Important: If WHITEHAVEN MEMORIAL PK. 8/4/2004 PITTSFORD, NEW YORK 21. Signature of Funerat Service L 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD any 20852 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death tmmediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Completed by Physician/Medical as the IF FEMALE 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day detached for in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATRIAL FIBRILLATION COMPRESSION FRACTURE 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: 1 🖾 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturat 5:30 PM JULY 9, 2004 1 ☐ Yes 2 🛛 No FALL 2 X Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number MD City or Town, State) 1515 DUNSTER ROAD, ROCKVILLE, Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 | Homicide RAPHAEL HOUSE 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certitier

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical .n 24 hou. •he Funeral D completely

Manyiand

Baltimore, Maryland 21215-0036

State

Registrar

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31. Date tiled (Month, Day, Year) AUG 05

29b. Signature and titte of certitier

PATRICIA TOMSKO NAY, M.D., 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAMI

6121 MONTROSE ROAD, ROCKVILLE, MD

29c. License number

D51910

29d. Date signed (Month, Dey, Year)

AUGUST 3, 2004

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year NANCY JULY 19, 2004 FARLEY HEIER 8:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** CASEY HOUSE - MONTGOMERY HOSPICE ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

JUNE 27, 1 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 □ F Yrs 1908 WEST VIRGINIA Director 224-62-9024 96 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. Counts 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla pepertment of Health and Mental Hyglene. Importent: If the 27 Is marked other than "netural", or Items 23a or 28e-f show any injury or gither treumatic event. If a Macincal Examiner must be notified as 1 ☐ Yes 2 ☐ No Director MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 15100 INTERLACHEN DRIVE, #1008 20906 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. þ 3 XWidowed 4 □ Divorced Spacify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES Α. FARLEY MARY MAYNARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15100 INTERLACHEN DR., #1008 SILVER SPRING, MD 20906 JAMES OLIVER HEIER, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) NATIONAL CREMATORY 7/23/2004 FALLS CHURCH, VA 21. Signature of Funeral Service EDWARD SAGEL FUNERAL DIRECTION, INC.) onald 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Enysician CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy requires that the death in the pasi 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. the Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown CONGESTIVE HEART FAILURE Completed 24a. Was an ADVANCED DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? page 2 s certificate has autopsy performed? Yes 2 2 No Division of Vital 1 ☐ Yes 1 ☐ Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Cher (Specify) HOSPICE ္က 1 ☐ Yes 2 ▼No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of perso co reted cause of death (Item 23a) (Type, Print)

Registrar

2004

31. Date filed (Month, Day, Year)

CHARLES HARRISON, M.D., 600 S. FREDERICK AVENUE, #200 GAITHERSBURG, MD 32. Registrar's Signature Darker

20877

			1 - For State Registrar	State of Ma	aryland				ealth a		ental Hy	/giene Reg. No.	n L	251	29
	Physici /Medic		Decedent's Name (First, Middle, Las Jeffrey Turner H.	*							2. Date of De Month July	eath Day	Year 2004	3. Time of 3:32	Death P M
	Examin		4a. Facility Name (If not institution, give Holy Cross Hospi						Location of		,	4c. County of Death Montgomery			
	Funeral Director		5. Social Security Number 6. Sec. 215-58-9116 11 Usual Residence of Decedent	X M 2□F	52	t birthday) Yrs.	If Under Months	n 1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Nov • 2	rth a <i>y, Year)</i> 1, 1951		place (State or ntry) land	Foreign
	Maryland a-f ehow	tor	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits 1 □ Yes 2 1 No			
	with the	Director	10e. Street and Number 5 Puritan Place				10f. Zip					-	of What Cour	ntry?	
9036	d within 72 hours after deeth with the Maryland Jiene. I than "natural", or items 23a or 28a-f ehow I're Madical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Ever in U.S.	If Yes, specify Cuban, Mexican, Puerto Rican,					cify Yes or Neican, etc.)	or No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	i within 72 iene. r than "nai	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	+)	(Give kind of work done during most of working life. DO NOT use retired)					nd of Business/Industry					
/land	othe	To Be C	17. Father's Name (First, Middle, Last) Joseph Hill							er's Name nita	(First, Middle	, Maiden Sum	name)		
	and 2 shoul lealth and Mc m 27 is mark		19a. Informant's Name/Relationship (7) Jennifer M. Smit											Code)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 ie marked any injury erother traumatic es ones.		20a. Method of Disposition 1 Burial 2 🛣 Cremation 3 🗆 4 Donation 5 Other (Specify		20b. Place of Dispos			ne of		Jul	te 28,	3, 20c. Location - City or Town, State			ía.
Balti	permit. Departn Importa any inju	21. Signature of Funeral Service Licens		F22	anci	d Address	scoling sity l	ins F	'uneral	al Home Inc. Silver Spring, MD 20901					
	Physician		23a. Part Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line	θ.								Ъ	Onset and De	een
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. — Due to (or as a c. — Due to (or as a d. — Due to (or a) d	consequen	nce of):									
.O. Box 6	the death certifi y the attending iched for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ath 3 🗆		ctopic pregnancy ther (specify)					23d. Date of delivery Month Day Year				
Records, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death bu	t not resultir	ng in the un	derlying c	ause grve	n in Part I.			Alexandria, Virginia 1 Home Inc. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 2 & Neck Years 23d. Date of delivery Month Day Year tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Munknown 5 an Interval Server Se			
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	To the Hospital or A within 24 hours efter To the Funeral Direction of the funeral birection by the funeral filled in by	Medical	29a. Certifier 1 IX Certifying Phy (Check only one) 1 IX Certifying Phy 2 I Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination	dge, death and/or inv	occurred estigation,	at the time in my opi	e, date and inion, deat	d place, an th occurred	d due to the d at the time,	cause(s) and r date and place	manner as sta e, and due to	ited. the cause(s)	
}	To T Som	Σ	29b. Signature and title of certifier	waz				License	number	Ŧ		29d. Date sign			
			30 Name and address of person who co	ompleted cause of de	ath (Item 23	Ba) (Type, F						sbur			313
	Sta Registra		31. Date filed (Month, Day, Year) JUL 27 20	32. Registrar	r's Signature	5	do	acts.	/				9		

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			for State	State of Maryla			d Mental Hy	giene	05100
			Registrar		Certifica	ate of Death	F	Reg. No. UU	25430
г	Dharia		1. Decedent's Name (First, Middle, Last)	. 1		3	2. Date of Dea		3. Time of Death
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9	s 1 and 2 t Health item 27 other tra		20a. Method of Disposition		Place of Disposition (N	ame of		20c. Location - City or	
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Baltimore,			21. Signature of Funeral Service License	NR 4 (7)	CHAMBERS C	and Address of Facility	-3-2004	RIVERDALE,	MD.
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	-		30. Name and address of person who con						\
			AMY STONE, M. 31. Date filed (Month, Day, Year)			AVE. N.W.,	WASHINGTO)N, D.C. 20)037
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			1 - For State Registrar	State o	f Marylar		artment rtificate					giene	001	254	31
	Physici	an	1. Decedent's Name (First, Middle William	e, Last) Stephen		Hartt	er				Date of Dea	Day			of Death
	/Medio		4a. Facility Name (If not institution		m <i>ber)</i>	nar c.		Fown, or	Location of		ı1y 30		04 County of Deat	8:15	5 A M
	_ Xaiiiii		Mariner Health	ethesda	a	Beth					M	lontgome	ry		
	Funeral		5. Social Security Number 380-24-5854	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. 75	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		Date of Birt (Month, Da) ecember	h v, Year)	Co	nplace (State Untry) nigan	e or Foreign
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	arylan show	_	10a. State 10b. County			ty, Town or Lo								10d. Inside	City Limits
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36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evarilizar must be notified at	ьу F	1 ☐ Never Married 2 ☒ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	ed 1 X Yes 2 □ No Korean If Yes, Give Year of Dates: War			n 1 □ Yes 2 No Specify:					Specify: White		
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Maryland	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relations		c -		•						r Town, State, Z		
d)	1 and Healtl Iem 27		Marguerite T. F 20a. Method of Disposition	lartter/wi	20b. F	Place of Dispo	sition (Nam	e of		Det Date	-		land 20		
ПOП	Pages int: If ii		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from Specify)	State	cemetery, crei tgomery				august 2004	5,	Bet	hesda,	Maryla	and
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Fundal Service Litensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501											Inc.	
			23a. Part 1. Extend the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Betwee												etween
	Pnysician /Medical	(0)	Immediate Cause (Final disease or condition resulting in death) Pneumonia Pneumonia										Onset an	u Death	
	Examiner		Due to (or as a consequence of): Myocardial Infarction												
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Litter University Cause (Disease or injury		(or as a conseq		II C CIO								
	be executed sician and burial-transit	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or as a consequence of):												
8760,	the death certificate be executed y the attending physician and ached for use as the buriat-transit	calE	d.												
9	tificate I og physi as the t	D		a.											
Вох	eath certific attending p	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy							230			d. Date of delivery Month Day Year		
0	at the dea by the ai	Physicia	1 Yes 2 No		4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown						World Day			Day	. 02/
٥.	igned by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute t			the cause of	f death?	
ords	w require been sig should b										1 🗆 Y	es 2	X No 3 ☐ Pro	bably 4	Unknown
3ec	4 8 0	Completed									24a. Was a autop	sv	24b. Were aut prior to c death?	opsy finding ompletion of	
Vital Records,		e Col	25. Was case referred to medica	ıl					26 Blace	of Dooth (C		med? 2 No	1 🗆 Yes	2 🗌 No	
ΓV	X Silo	To B	examiner? 1 \(\sum \text{ Yes} 2 \) \(\text{X} \) No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe			<i>theck only of</i> 5 ☐ Resid		5 □Other (Spec	ify)	
n of	fter ner		27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury		Bc. Injury Work	at c?	28d	l. Describe h				
Division	en or:	ficat		not be	of njury - At h	ome, farm, str	M reet factory.		Yes 2 □ I		Location (S	treet an	d Number or Ru	al Route Nu	ımber.
Οİ	al or Attendii s after death. al Director: A ed in by the fu	Certification;	4 - Homicide	nined 289. Place buildi	n , etc. (Specif	(y)	001, 1401019,	3.1100			City or Tow				
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by the	edical (29a. Certifier 1 Certifyin (Check only one) 1 Medical	ing Physician: To best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. I Examiner: On a basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as manner stated.								(s)			
	To the To the Comp	M	29b. Signature and title of certific	A					number		2		e signed (Month	, ,	
	511			4	-			5012	48			Jul	y 30, 2	JU4	
			30. Name and address of person Alan R. Morriso					d.,	#300	, Rock	ville	, Ma	ryland	20852	
	Sta Registi		31. Date filed (Month, Day, Year, AUG 0 1	32. P	egistrar's Signa		Spo								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item# 4c,10b, per Phy, FH, 9835, 9/16/04 TT

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) **Physician** 7:00 A <u>August</u> 3, 2004 Irene Shargel Heifetz /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore North Oak Nursing Home <u>Baltimore</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🛣 F Yrs. Jan 26, 1913 91 Baltimore, MD Director 214-30-6056 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23e or 28a-f show must be notified at Baltimore 1X Yes 2 □ No Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 725 Mount Wilson Ln, #34-A 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "netural", or iten It e Medical Examiner filed within 72 hours after Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient importent: If tem 27 is marked other that any injury or other traumetic event, Italy once. Teacher <u>Education</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rebecca Schearr ပ Isaac Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Martin C. Shargel/Son 11021 Haislip Ct, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Hebrew Young Mens Assoc Aug 5, 2004 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Late effect cerebrovascular accident /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Atrial Fibrillation Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Diastolic Dysfunction 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2X No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 1) Karem I Ballett, M.D. D0058676 August 4, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 6 2004

Karen L. Babitt, MD 25 Main St, Suite 200, Reisterstown, MD 21136

32. Begistrar's Signature

			1 - State RegistramEND ITEM #	State of Ma			artmer	nt of H	ealth an	nd Menta	l Hygi	,		256	33
	Physic	ian	Decedent's Name (First, Middle, La	st)						Mor	of Death		Year	3. Time of	
	/Medi	cal	Joseph Ingegneri 4a. Facility Name (If not institution, giv				41 03				y 23			1:30	A M
	Exami	ner	20812 New Hampsh:						Location of C eville				nty of Deat ontgon		
	Funeral		5. Social Security Number 6. S		e (In yrs.	last birthday)	If Under	r 1 Year	If Under 24		of Birth				or Foreian
	Director		213-09-8140 Usuel Residence of Decedent	M 2 F	84	Yrs.	Months	Days	Hours	Min. Oct.	nth, Day, 1	1919	Mary	hplace (State of untry) 71and	
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Modical Erer met met be published at	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	
	88-f	by Funeral Director	Maryland Montgom	ery	Bro	okevil									2 □ No
	with t	ä	10e. Street and Number				10f. Zip				10	g. Citizen o		untry?	
	eath	era	20812 New Hampsh:	12. Was Decedent I	Ever in II	S 12 1		833	nania Origin	2 (Cassin Va	ar Na		USA	rican Indian.	
"	riter	문	1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ N		42- '			n, Mexican, P	? (Specify Yes uerto Rican, e	tc.)		lack, White		
8	rel', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	19		1 ☐ Yes	2[X No	Specify:			Spec	ify: Wh	nite	
21215-0036	72 hc natur	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usua	al Occupa	tion uring most of	working	16	Bb. Kind of	Business/I	Industry	
121	vithin ne. hen	m p	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT u ness		uring most of	g		Elect	rical	Contr	actin
	filed v Hygie other t		6th 17. Father's Name (First, Middle, Last,)						Name (First				- Ooner	
and	d be f antal h sed of	Be C	Phillip Ingegner:							Name (First, I			атө)		
Maryland	should be nd Mental marked o	္	19a. Informant's Name/Relationship (19b. Mailin	na Address	(Street a		r Rural Route			n State 7	in Code)	
	and 2 ; salth ar n 27 is		Patti Marks- Daug							Ave. H					
Baltimore,	- i = =		20a. Method of Disposition		20b. P	lace of Dispo	sition (Nar	ne of	. I	Date	20	c. Location	n - City or 1	Fown, State	
Ē	Pages nent of ant: If it		1 Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify			te of I			- 1	/26/200	4	Silve	r Spr	ing, M	D
a	permit. Departri Importe any inju		21. Signature of Funeral Service Licer	1) 1		22	. Name an	d Address		Hines-F					
_	8958		Dendr C.	Wil	<u> </u>								Sprin	ng, MD	20904
200	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	L U a consequ	NO.		wc e						Approximate Interval Bets Onset and Concerns	ween Death
P.O. Box 68760,	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a d. d. 23c. If yes, outcome a 1 Live birth 4 Pregnant at 9 Unknown	of pregna 2	incy	Ectopic pr						ate of delik		'ear
ecords, F	uires thai signed t	þ	Part II. Other significant conditions of	ontributing to death bu	it not resi	ulting in the ur	nderlying c	ause giver	n in Part I.	23e		cco use co		the cause of de	eath? Inknown
00	w requires been si	Completed								24a	Was an	24b	Were auto	opsy findings a	available
α	The lay	mo								- _	autopsy performe	d?	prior to co death?	ompletion of ca	use of
Vital	icien: Th certificate ector, pag	0	25. Was case referred to medical						26. Place of I	Death (Check		No	1 ☐ Yes	2∐ No	
_ \	nysici nis ce direc	ToB	examiner? 1 ☐ Yes ➤ No	Hospital: 1 Inpatier	nt 2 🗆	ER/Outpatient	t 3□ DO	Other		g Home 5		e 6 🗆 Ot	her (Speci	fv)	
ion of	inding Pt ath. r: After the		27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of Injun (Month, Day	Year)	28b. Time of Injury	M 2	8c. Injury Work? 1 🗆 Y				injury occu		<i>"</i> .	
Division	el or Atte s after de il Directo id in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specify	me, farm, stre	et, factory	, office	-	28f. Loca City	tion (Street or Town, S	et and Num State)	ber or Rur	al Route Numb	7⊖ <i>r</i> ,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical (29a. Certifier (Check only one) Certifying Ph	ysicien: To the best o niner: On the basis of and manner stat	examınaı	wledge, death tion and/or inv	occurred a estigation,	at the time in my opi	, date and planion, death o	ace, and due t	o the caus time, date	e(s) and m and place	anner as s , and due t	stated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	7/			29c	. License	number		29d.	Date sign	ed (Month,	Day, Year)	
	30		1 Sant	Call in	nD		D	391	90		Ju	ly	Z3.	2009	1
	9		30. Name and address of person who				,						-		
			Garrett Reilly,				Ct. S	uite	111 0	lney, N	D				
	Sta Registr	10	31. Date filed (Month, Day, Year) JUL 26 20	32. Registra		ture &	Spo	uls	/						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** P^{M} 28. 2004 Ju1v 1:30 Kargbo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's

9. Birthplace (State or Country) Adelphi
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9010 Riggs Road #107 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**X**1M 2□F 51 Oct 9 1952 Sierra Leone 228-21-8280 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "netural", or Items 23a or 28a-f show the Modical Examinar must be multified at 1 ☐ Yes 2 🕅 No MD Prince George's Adelphi Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20783 9010 Riggs Road #107 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: black þ 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 4 licensed practical nurse 18. Mother's Name (First, Middle, Maiden Surname) other treumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 Is marked oth
any injury or other treumatic event Santigie Kargbo Aminata Fornah ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8648 Brae Brook Drive, Lanham MD 20706 Hawah Bah/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition ¿p Burial 2 □ Cremation 3 □ Removal from State Aug 7 2004 Geo. Wash Cemetery Adelphi, MD A □Donation 5 □ Other (Specify) 22. Name and Address of FacilityHines-Rinaldi Funeral Home Inc. 21. Signature of Syneral Service Licensee 11800 New Hampshire Ave Silver Spring MD 20904 anda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ,st Physician/Medical Examiner signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) 68760, IF FEMALE: Records, P.O. Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò q CHRONIC RENAL 1 ☐ Yes 2√2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has tirector, page 2 s autopsy performe EFFUSION ICAPDIAL URAL 2 - No 2 No 1 TYes Division of Vital or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Certification: To 1 Yes 2 No 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: Al investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Manure and title of certifier A. 2459 7,28,04. 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohammed Mannan 3331 Toledo Ter #206 Hyattsville MD 20782-8157 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 02 2004 AUG Registrar

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment ertificate				lental Hy	giene)04	25435
	Physici /Medic		1. Decedent's Name (First, Middle) Amedou	n Khe	ir					2. Date of D	eath Day	2004	3. Time of Death
	Examir		4a. Facility Name (If not institution,	•	•	-		Location o				ounty of Death	
	Funeral		Northwest Ho 5. Social Security Number		enter Age (In yrs. last birthda			re (ltimor	
	Director		578-98-9596	1 🛣 M 2 🗆 F	5.4 Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D. 9 / 0 1	ay, Year) /49	Sud	place (State or Foreign intry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	Maryl f sho	to		imore	Baltim		ount	у					1 X Yes 2 □ No
	th the or 28a s notifi	Director	10e. Street and Number			10f. Zip					10g. Citize	n of What Cou	ntry?
	ath wil	raiD	8239 Vosges			2.	1244	1			Suda	an	
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avant, the Medical Examination must be notified at	by Funerai	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decede Armed Force od 1 Yes 2 If Yes, Give Year or Date	es? (X)No	3. Was Deced If Yes, spec 1 ☐ Yes 2		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or Ne Rican, etc.)		. Race - Amen Black, White, pecify: black	etc.
5-0	72 hc	etec	15. Decedent' (Specify only highest	s Education grade completed)	16a. Dec (Gi	cedent's Usua ve kind of wor DO NOT us	l Occupa k done d	tion uring most	t of worki	ng	16b. Kind	of Business/In	ndustry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4	Or 5+)	. <i>DO NOT us</i> i					KILIM	ait Er	mbassy
d 2	il Hygi other	Be Cc	17. Father's Name (First, Middle, L	ast)	011	100 0			r's Name	(First, Middle			праззу
ylar	Menta Menta arked	To B	Mohammed Kh	eir				Amn	a	Sul	liman		
Baltimore, Maryland 21215-0036	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationsh Catherine Dix		wife 823	iling Address 9 V o	(Street a	<i>nd Numb</i> e s Rd	r or Rura	<i>l Route Numb</i> B alti r	er, City or T	own, State, Zip Md . 2	2 1 2 4 4
ore,	of Hea		20a. Method of Disposition 1 ★ Burial 2 □ Cremation		20b. Place of Dis	position (Nam ematory or oti	e of her place	,		ate	20c. Loca	tion - City or To	own, State
Ē	ment ment fant: h		'4 □Donation 5 □ Other (Sp		" George	Wash	ing	ton'	/28			phi, N	
Bai	permit. Pages 1 Department of H Important: If its any injury or ot		21. Sign tur of Funeral Sen	icensee	064							rtuary	
			23a. Part 1. Enter the Jsease, or c	complications that cau	sed the death. Do not e					-		hingto	Approximate
	Physician		Shock, or he at fullure. List of Immediate Caus an inal disease or condition	nly one cause on eac	n line.							7	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):								
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	, Kei	nal tailu	re							
ó,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or	as a conseq ence of):								
8760,	icate be executed physician and s the burial-transit	dica		d						_		-	
Box 6	death certific e attending p id for use as f	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							230	l. Date of delive	arv
.O.	0 0	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No		t at time of death 5	☐Ectopic pre ☐ Other (spe					1	Month	Day Year
٥.	that the ed by th detache		9 ☐ Unknown Part II. Other significant condition			underlying ca	IISA TIVAI	n in Part I		23e Did t	ohacco use	contribute to th	ne cause of death?
rds	w requires that been signed should be det	ed by										lo 3 ☐ Prob	
Vital Records,	2 8 8	Completed								24a. Was autop	osy 🗾	4b. Were auto	psy findings available appletion of cause of
Tal F	ician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical							1 ☐ Yes	med? 2 D No		2 No
Į V	Physician: r this certificanal director,	To B	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2 HEN Outpati	ent 3 DOA	Other			(Check only only only only only only only only		Other (Specify	
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	To the Hospital or Attanding Physician: The within 24 hours after death. To tha Eunaral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier Check only one) Certifying 2 Medicel E	Physician: To the be kaminer: On the basis and manner	est of my knowledge, dea s of examination and/or stated.	nth occurred a nvestigation, i	t the time	e, date and nion, death	place, a	nd due to the d at the time,	cause(s) and date and pla	d manner as stace, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1		29c.	License	number			29d. Date si	gned (Month, I	Day, Year)
}	4		D. Lawas	tentier		H	2005	133	9		July 2	26,20	04
			30. Name and address of person w	ho completed cause of	of death (Item 23a) (Type	Print) Pa	ude	ellsto	201	MID	2/1	33	
ľ	Sta Registra		31. Date filed (Month, Day, Year)	2004 32. Regi	strar's Signature	d. Sa Spi	uks	/					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:40 2004 Kolig Wilhelmine /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 910 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Austria 94 Director N/A Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If tem 27 ie marked other then "neture!, or items 23e or 28e-1 show any injury go other treumatic event, the Madical Evanthar must be required at any injury go other treumatic event, the Madical Evanthar must be required at once. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes Ž No Silver Spring Maryland Montgomery Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20904 Austria Funeral 1425 Crockett Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 本本No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify þ 3 Widowed 4 □ Divorced ieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Compi College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) Home 17. Father's Name (First, Middle, Last) Be Pauline Kiesling Wilhelm Zillinger ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Crockett Lane Silver Spring, Maryland 20904 Helmut Kolig / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (\$pecify) Lincoln Crematory 7/28/2004 Brentwood, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home 21. Signature of Funerat Service Lie ensee 11800 New Hampshire Avenue Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** recar 7 dice resulting in death) /Medical Due to (of as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 24a. Was an has e 2 med? certificate 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Hipatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) After thi funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10059228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PASMANIK, M.D #109 Laurel Road Meade 32. Registrar's Signature 31. Date filed (Month, Day, Year) sarks State 26 2004 Registrar

			1 - For State Registrar	State of Maryl	and / Depa		Health an	d Mental Hyg	giene	25437
	Physici	an	Decedent's Name (First, Middle, La	est)				2. Date of Dea Month	th Day Year	3. Time of Death
	- /Medic		Cecilia M. Kirby					August		8:37 P M
1	Examir	ner	4a. Facility Name (If not institution, given			4b. City, Towr	n, or Location of D	eath	4c. County of Death	
			Shady Grove Adven			Rockvil			Montgomer	-
	Funeral Director			Sex 7. Age (In) 1□ M 21 F 72	rs. last birthday) Yrs.	If Under 1 Ye Months Day		Hrs. 8. Date of Birth Min. (Month Day May 25,	1932 Penn	place (State or Foreign ntry) sylvania
	and wo		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	he Mary 8e-f sho otified s	ector	Maryland Montgom	ery P	otomac					1 □ Yes 2 No
	with t	늄	10e. Street and Number 11812 Charen Lane			10f. Zip Code 20854			0g. Citizen of What Cou	•
	eath	eral	11. Marital Status	12. Was Decedent Ever in	nlis 12 i				Jnited State	
920	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-1 show its Madical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify C		? (Specify Yes or No- uerto Rican, etc.)	Black, White,	etc.
21215-0036	in 72 hou n "neture	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece (Give life.	dent's Usual Occ kind of work do DO NOT use ret	cupation ne during most of ired)	working	16b. Kind of Business/Ir	dustry
212	d with giene	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Resea	arch Che	emist	1	Federal Gov	ernment
land	ild be file lental Hyg ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last Cuyler Poor)				Name (First, Middle, I Shoop	Maiden Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show amy injury or other treumatic event, the Muchael Examinator must be notified at once.		19a. Informant's Name/Relationship (Philip S. Kirby/H		19b. Mailir 11812	ng Address <i>(Stre</i> 2 Charer	eet and Number of	Rural Route Number	; City or Town, State, Ziparyland 208.	o Code) 54
Baltimore,	ent of Hea		20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from State	b. Place of Dispo cemetery, crer ate Of I	natory or other p leaven	olace) Aug	gust 7,	20c. Location - City or To Silver Sprin Maryland	own, State
Balti	permit. I Departm Importer any inju		21. Signature of Funeral Service Lice	nsee	Cemeter Ro 1346 Ro	Name and Add OCKVILLE	dress of Facility R	obert A. P 800 West Mo	umphrey Fur ontgomery A	eral Home/ venue
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons	sequence of):			M CNARY		Approximate Interval Between Onset and Death
P.O. Box 68760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnal			23d. Date of delive	ery Day Year
	quires than signed I	by	Part II. Other significant conditions	contributing to death but not			-	23e. Did tob	acco use contribute to the s	ne cause of death?
I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed						24a. Was ar autops perform	y prior to conted? death?	psy findings available mpletion of cause of 2 No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of I	Death (Check only one	9)	
of \	di 5	2	1 ☐ Yes 2 DANo	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	t 3 DOA	Other: 4 - Nursin	g Home 5 Reside	nce 6 Other (Specify	y)
	Attending Padeath. ctor: After to		27. Manner of Death 1 Statural 5 ☐ Pending 2 Accident investigatio		28b. Time of Injury	28c. In W M 1	jury at łork? □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	or A after Dire	Certification;	3 Suicide 6 Could not be determined		t home, farm, streecify)	eet, factory, offic	ee .	28f. Location (Str City or Town	eet and Number or Rura , State)	l Route Number,
	To the Hospitel within 24 hours To the Funerel completely filled	Medical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my lininer: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the restigation, in my	time, date and play y opinion, death o	ace, and due to the ca ccurred at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	To the to the complex	Σ	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Month,	Day, Year)
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_			(DAVID SRCY)		dicia/C	In Drie	ir Rock	culle Ma	1. 2085	C!
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	Soul	1			

Robert C, Kocher, Sr. A Softy Name Production of prod				1 - For State Registrar	State of Mary		artment of rtificate of		Re	g. No. 0 1	251.38
School Internal School Int		/Medi	cal	4a. Facility Name (If not institution, give s	Sr.		4b. City, Town,	or Location of Dea	July 27,	Day Yeer 2004	3. Time of Death 11:05 P M
Year Year				5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Yea	r If Under 24 Hr	. (Month, Day,	Montgome 9. Birtl (Co)	ry hplace (State or Foreign
Lawrence Kocher 19a. Informants Name/Residential (Type, Print) 19b. Mailing Address (Street and Number of Plusal Poules Number, City or Town. State, 2p Code)		ne Maryland 8e-f show	ctor	10a. State 10b. County Maryland Montgomer		•					10d. Inside City Limits
Lawrence Kocher 19a. Informants Name/Residential (Type, Print) 19b. Mailing Address (Street and Number of Plusal Poules Number, City or Town. State, 2p Code)		ath with the	ral Dire	10231 Carroll Plac			208				untry?
Lawrence Kocher 19a. Informants Name/Residential (Type, Print) 19b. Mailing Address (Street and Number of Plusal Poules Number, City or Town. State, 2p Code)	9036	ours after de irel', or item	d by Fune	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 EYes 2 □ No If Yes, Give				Specify Yes or No- rto Rican, etc.)	Black, White	e, etc.
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23a Part Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, processing in death pro	ryland	hould be file d Mental Hy marked othe metic event,	Be	Lawrence Kocher	ng Print)	105 144 11		Goldie	Starry		
23a Part Effect the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, processing in death pro	altimore, Ma	rmit. Pages 1 and 2 s spartment of Health an sportent: If item 27 is i y injury or other treui ice.		Susan Kocher- Wife 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 MRe '4 □ Donation 8 □ Other (Specify)	emoval from State	0509 Ob. Place of Dispo	Elmwood sition (Name of natory or other pla ty Memor	Rd. Nort	h Port, FI Date 20 02/2004 En nes-Rinal	L 34287 Oc. Location - City or T rie, PA Li Funeral	Fown, State
24a. Was an utopsy indings available prior to completion of cause of death? 24b. Ware autopsy indings available prior to completion of cause of death? 25c. Was case referred to medical examiner? 25c. Place of Death (Check only one) 25c. Place of Death (Check only one) 25c. Place of Death (Check only one) 25c. Was case referred to medical examiner? 25c. Place of Death (Check only one) 25d. Location (Street and Number or Rural Route Number, City or Town, State) 26c. Place of Death (Check only one) 26c. Place of Injury At home, farm, street, factory, office 26c. Place of Death (Check only one) 26c. Place of Injury At home, farm, street, factory, office 26c. Place and place, and due to the cause(s) and manner as stated. 26c. Place of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Manner of Death (Check only one) 27c. Man		/Medical Examiner	dicai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cause or in the interest of the inte	Due to (or as a cor	nphysema nsequence of):	er the mode of dy	ing, such as cardia	c or respiratory arres	t,	Interval Between
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The property of the property o	<u></u>	The law ate has b page 2 sl		25. Was case referred to medical					autopsy performe 1 ☐ Yes 2X	d? prior to co	impletion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shashank Patel, M.D. 2309 Shorefield Rd. Wheaton, MD 20902 State 31. Date filod (Month, Oay, Year) 32. Registrar's Signature	_	الله الله	To B	examiner? 1 Yes 2XNo 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injui Woo	ner: 4 🔀 Nursing H ry at rk?	ome 5 Residence 28d. Describe how	injury occurred	
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Shashank Patel, M.D. 2309 Shorefield Rd. Wheaton, MD 20902 State 31. Date filed (Month, Oay, Year) 32. Registrar's Signature		V within 24 To the FL completel		29b. Signature and title of certifier	and manner stated.	nination and/or invi	29c. Licens	e number	rred at the time, date	and place, and due to	Day, Year)
				Shashank Patel, M.	D. 2309 She	orefield	Rd. Whea		20902		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician FERNANDO** CHARRY LARA 22° 2004 ear July 12:15A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth Sept. 14,1920 **Funeral** 9. Birthplace (State or Foreign 1**™**M 2□F Months 83 Colombia Director None Usual Residence of Decedent with the Maryland works ' 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28e-f shov Cundina-Director Bogota 1 ☐ Yes 2X No marca 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Calle 94 #17-53 Apt. #502 None Colombia . death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X□Yes 2□No Specify: Colombian þ Specify: White 3 X Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry ormit. Pages 1 and 2 should be filed within 72 pertiment of Health and Mental Hygiene. proctent: if itam 27 is marked other than "nu yn njury or othar traumatic avant, the Mental Bs. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Poet/Writer Literature 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Justo V. Charry Mercedes Lara 19a. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21107 Tall Cedar Way Germantown, Md. 20876 Luz Helena Charry Delgado 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition July 31, 20c. Location - City or Town, State 1 Burial 2 Acremation 3 Removal from State Jardines del Recuerdo 4 □ Donation 5 □ Other (Specify) Bogota, Colombia permit.
Deportming importe any nju 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Acute Myocardial Infarction 2 Hours /Medical Due to (or as a consequence of): **Examiner** Cardiogenic Shock Z hours Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attanding Physicien: The law requires that the death certificate be executed burial-fransit Ventricular Arrythmia 2 Hours Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ director, page 2 should Be Completed 1 Yes 2 No 3 Probably 4 1 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending s after death. death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hin 24 hours at the Funaral C 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated. one) To tha 29b. Signature and title of pertifier 2 29c. License number 29d. Date signed (Month, Day, Year) M.D. D39671 July 22, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike Dr. Pankaj Lal M.D. Suite #100 Rockville, Md. 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Denewa. 26 JUL oaks Registrar

	_	For State Registrar				Ce	Artmer ertificat	te of	Death			Reg. N	<u>g</u> () () L	2544
,sician		Decedent's Nam	ne (First, Middle, La	st)							2. Date of D Month		ay	Year	3. Time of D
ledical			lliam Leed								July	20,	2004		10:05
aminer				ock Terra					r Location	of Death				y of Death	
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Physicia		Decedent's Name (First, Middle, Last) Irene Level L	venstein			July 24,		3. Time of Death 11:55a M
/Medic Examin		4a. Facility Name (If not institution, give street and number) Collingswood Nursing Home		4b. City, Town, or Rockv	Location of Death		4c. County of Montg	
Funeral Director		5. Social Security Number 6. Sex 1 M 2X F 7. Age (In 90	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		B. Birthplace (State or Foreign Country) Lithuania
the Maryland 28a-f show	Director		. City, Town or Lo				lg. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or		2461 McCormick Road		20850				SA
ours after des	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2808No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)		American Indian, White, etc. White
be filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. d other than 'natural', or tams 23s or 28s-f show event, If a Mudical Exacting from the twitting at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of won ()	king	6b. Kind of Busin	
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2 should and Men is marke sumatic	2	Isaac Sofronsky 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street a				ate, Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene important: a file and 23 and 24 show any injury or other traumatic event, the Medical Examination trained to indiffer at once.	1	1 Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispo cemetery, cren Cing Davi	sition (Name of natory or other place I.d. Mem Gd: Name and Addres	ns. 7/28	3/2004 nes-Rinal	Oc. Location - Ci Falls Cl di Fune:	and 20850 ty or Town, State burch, Virgini, ral Home 20904 Spring, MD
Physician Medical Examiner but site private and physician and private street but at the private street but and pri	dical Examiner	art1. Enite the disease, or complications that caused the canada shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition o	Pneumon: sequence of): Ischemic					Approximate Interval Between Onset and Death
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of prediction in the past 12 months? 4 Pregnant at time 9 Unknown	etel death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
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Physician this certif al directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe		th <i>(Check only one</i> ome 5 Residen		(Specify)
To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;	27. Manner of Death 1 Natural 5 Pending (Month, Day Yeal Investigation	28b. Time of Injury	Work		28d. Describe how		
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To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my 2 Medicel Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and mann e and place, and	er as stated. If due to the cause(s)
	Me	29b. Signature and title of certifier Alparalynnar	- M.D	29c. License	27660	29		Month, Dey, Year) 27, 2004
2		30. Name and address of person who completed cause of death (Alpana Goswani, MD 11119	Item 23a) (Type,	Print)		Rockwi 1		
Sta Registra		31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's S	ignature 🔭	Sporks		, ROCKVII	re, m	20032

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25. Was case referred to medical adambles of the cause of death of	760,	/Medical Examiner iciau and pnuial-transit	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		hronic Due to (or as	Obstr s a conseque s a conseque	ence of):	ve Pul	mona	ary D	iseas	5e				Onset and I	Death
Coronary Artery Disease 1 Yes 2 No 3 Probably 4 @Unknown 24a. Was an allopsy performed? 1 Yes 2 No 3 Probably 4 @Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 @Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No No Year No Year Yes 2 No No Year No Year Yes 2 No No Year Yes 2 No No Year Yes 2 No Year Yes 2 No Year Yes 2 No Year Yes 2 No Year Yes 2 No Yes 2	Box	death e atter	nysician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 4	Live birth	2 Fetal c	death 3□									*	/ear
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of permando completed cause of death (Item 23a) (Type, Print) Rahul Gilotra, M.D. 12016 Georgia Avenue, Wheaton, MD 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sign	ttenc death ctor: / the	ical	3 ☐ Suicide 6 ☐ Cou	ld not be	le Place of Ir	niury - At hon	ne farm str					28f. Location (Street a	nd Number	or Rura	l Route Num	ber.
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30. Name and address of per and completed cause of death (Item 23a) (Type, Print) Rahul Gilotra, M.D. 12016 Georgia Avenue, Wheaton, MD 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	\	1 1		10/11/	(//	fru-			230									
Rahul Gilotra, M.D. 12016 Georgia Avenue, Wheaton, MD 20902 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10	1	Marco	/K	VY	J don't /!:	030\ 75	Deie 1\									
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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Louie Day Year 35 pm **Physician** KOW GEE July 2004 /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Columbia ountu General Hospital Howard Howard If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days 1 M 200 Director 219 98 1497 72 Aug. 20, 1931 China Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28e-f show 10b. County 10d. Inside City Limits 1 Yes 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ir than "naturel", or Iteme 23a or 6023 Wild Ginger Court 21044 China by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 □ Yes 2 ★ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Asian Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other ther any injury or other treumatic event, ILAIN 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lau Hung Fou Wong Yen Chung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Place of Disposition (Name of cemetery, crematory or other place)

Court Columbia, Maryland 21044

Date 20c. Location - City or Town, State Siu Hong Louie / Husband
20a. Method of Disposition 20b. Place Importent: If it any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specky) 7/31/2004 Rockville, Maryland Parklawn Mem. Park 21. Signature of Funeral Sarvice Ucensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 20904 11800 New Hampshire Avenue Silver Spring, MD 73a. Part1. Ente the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h, art failure. List only one cause on each line. Approximate Interval Between Onset and Death Inmediate souse (Final disease or condition resulting in death) Physician Cancer 2 months /Medical Due to (or as a Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>^</u> 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy perform certificate 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funerel Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier D56531 0 Lane, Columbia 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Li 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 26 serva 2004 JUL souks Registrar

4a. Facility Name (If not institution, give street and number)

ELEANOR PATRICIA

LAW-YONE

4b. City, Town, or Location of Death

Month

July

Day

29

Year

2004

4c. County of Death

0
Physician
/Medical
Examiner

Funeral Director the Maryland Show r than "natural", or items 23a or 28e-1 shov the Medical Examiner must be notified at Hygiene.

death filed within 72 hours after permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: If Itam 27 Is marked other ti
any injury or other treumatic event, III
once.

Baltimore, Maryland 21215-0036

Privsician /Medical Examiner

attending physician and for use as the burial-transit P.O. Box 68760 Records, of Vital Division Hospitel or Attanding

ELEANOR

Examiner Completed by Physician/Medical Be P Certification: Medical

Director 10e. Street and Number 10f. Zip Code 2501 Musgrove Road 20904 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 2 Years Elementary/Secondary (0-12) School Teacher 17. Father's Name (First, Middle, Last) Be Eric Percy-Smith Daw Pwa Tint 19a. Informant's Name/Relationship (Type, Print) Marjolaine Nyo/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Bleed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🖾 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deep Venous Thrombosis 24a. Was an autopsy performe Lower Extremity Osteomyelitis 1 ☐ Yes 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 XNatural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide

Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 ☑ F Months Yrs 91 182.46.4848 Dec.22, 1912 | Mandalay, Burma Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Maryland | Montgomery Silver Spring 10g. Citizen of What Country? U.S.A. 14. Bace - American Indian Black, White, etc. Specify: Asian 16b. Kind of Business/Industry Education 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Nash Drive, Queenstown, Maryland 21658 20c. Location - City or Town, State Gate of Heaven Ceme. 08/02/2004 Silver Spring, Maryland 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME, INC.
11800 New Hampshire Ave, Silver Spring, MD 209
Approximate Interval Between Onset and Death мр 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 Yes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 07-29-2004 D54347 completed cause of death (Item 23a) (Type, Print) Neeraj Chopra, M.D., P.O. Box 83819, Gaithersburg, Maryland 20883

State

Registrar

31. Date filed (Month, Day, Year)

AUG 02

2004

within 24 hours a

outs

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** July 2004 30, /Medical George Veikko Lehto 6:58 p 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Holy Cross Hospital Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 81 Dec. 4, Director 029-16-1543 1922 Massachusetts Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Maryland Montgomery Silver Spring 1 ☐ Yes 2 No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ŏ 20901 or Items 23a 1007 Laredo Road U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ⊟Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene othar than 5+ Physicist Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit iment of Health and Mental Hitant: If item 27 is marked other. Be Hulda Maria Unknown ပ္ Sulo Veikko Lehto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric A. Lehto / son 19523 Caravan Dr., Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its eny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory August * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Alexandria, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 2090 Approximate Interval Between Onset and Death 23a. Part1. Ent/ r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear filture. List only one cause on each line. Immediate Carse (Final disease or condition **Physician** Myocardial Infarction resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U. durying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performed' certificate 1 ☐ Yes 2 NNo Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lowelfalls, us 00057304 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eirene Koroulakis, 10810 Connecticut Ave., Kensington, Maryland 20895 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 03 AUG Registrar

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	Physic	ian	1. Decedent's Name (First, Midd	lle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medi		Theodore Lig								August			11:35 A M
4	Examir	ner	4a. Facility Name (If not institution	on, give street and num	ber)		4b. City,	Town, or	Location of	of Death			inty of Death	
			Larkin Chase					wie	N Order	0.4.1.00				eorge's
	Funeral Director		5. Social Security Number 146-20-2200 Usual Residence of Decedent	6. Sex 7 1 ★ M 2 □ F	79 79	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day Nov. 7,	1924	9. Birth Cou New	place (State or Foreign intry) Jersey
	land bw		10a. State 10b. Count	у	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Mary f sh	ō	Maryland Pri	nce George'	s	Takoma	Park							1 ☐ Yes 2 🛣 No
	1 the	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	intry?
	n with	0	1612 Drexel	Street				2091	2				USA	
	deat	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)	14. F	Race - Ameri	
9	after or Ite	正	1 ☐ Never Married 2 ☐ Ma	rried 1 Yes 2			rres,spec 1 □ Yes 2			, Puerto	Hican, etc.)		Black, White,	
8	72 hours after death with the Maryland natural', or items 23a or 28a-1 show dical Examinat must be inclified at	d by	3 Widowed 4 □ Divorce	Year or Dat		3-46	10165 2	ASJ INO	эреспу.			Spe	_{icify:} Whit	
21215-0036	be filed within 72 hours after death with the Marylan nat Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be redified at	Completed		nt's Education est grade completed)		(Give	dent's Usual kind of won	k done d	luring most	of worki	ng	16b. Kind of	f Business/Ir	ndustry
121	within ene. then	E D	Elementary/Secondary (0-12)	College (1-	for 5+)	1	DO NOT us						_	(22222
2	filed with Hygiene. other than		17. Father's Name (First, Middle	5+		FIE	ctric	al E			(First, Middle,			nment/NAVSE
an	ntal led o	Be											arre)	
2	12 should be filed w n and Mental Hygier is marked other ti raumatic event, In	2	Stephen Lignu 19a. Informant's Name/Relation			19h Mailir	na Address	(Street a			Vilima: Route Numbe		um Ctata Zi	- Codel
Maryland	ages 1 and 2 should b ont of Health and Ments it: If Item 27 is marked y occurrent traumatic e		Thomas Ligis,								Bowie,			o Code)
	1 and Health tem 27		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nam	e of			-	20c. Locatio		own State
Baltimore,	Pages nent of int: If it		1 ☑Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (ate	emetery, cren Gat	natory or oti e of	her place Heav	en		gust 5,			
∄			21. Signature of Funeral Service				. Name and		e of Eacilit		004	Silve	r Spri	ing, MD
Ba	permit. Departr Importa any inji		Avan	De Inle	رميده	Fr	ancis	J.	Colli	ins I	uneral			, MD 20901
	Fnysician /Medical Examiner	ıer	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Undertyling	a. <u>Cardi</u> Due to (or	ac Arr	hythmi uence of):		of dying	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
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oʻ	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a conseq	uence of):								
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9	artifica ing pl e as t	Med	IF FEMALE:					-						
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Feta ntattime of d	I death 3	Ectopic pre Other (spe						Date of delive Month	ery Day Year
s, P	requires that een signed b hould be dete	by P	Part II. Other significant conditi	ons contributing to dea	th but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	acco use co	intribute to th	he cause of death?
Ď	w require been sig should b										1 □ Ye	s 2 No	3 🗆 Prob	pably 4 DUnknown
Vital Record	> 0 0	ompieted									24a. Was a		. Were auto	psy findings available
æ	o - 0	E									autops perform	y ned?	prior to cor death?	mpletion of cause of 2□ No
ital		3e C	25. Was case referred to medica	ıl _					26. Place	of Death	(Check only on		1 195	2[] 140
f V	Si Si	To B	examiner? 1 □ Yes 2 x □ No	Hospital: 1 ☐ Inp	atient 2	ER/Outpatient	3 DOA	Othe			ne 5 Reside		ther (Specif	v)
n of			27. Manner of Death 1 XNatural 5 Pendi	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28	c. Injury Work			8d. Describe ho			,,
<u>Ö</u>	Attending r death. sctor: Afte by the fune	catio	2 Accident invest	igation			M		es 2 🗆 N	io				
Division		ertification;	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of	Injury - At ho , etc. (Specify	ome, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	reet and Nur , State)	nber or Rura	l Route Number,
	ital curs at ral D	O												
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1	ng Physician: To the b Examiner: On the bas and manne	is of examina	wledge, death tion and/or inv	occurred at estigation, i	t the time n my op	e, date and inion, deati	l place, a n occurre	nd due to the ca d at the time, da	use(s) and rate and place	nanner as st , and due to	tated. the cause(s)
	To With	2	29b. Signatule and title of certifie	er			29c.	License	number		25	d. Date sign	ed (Month,	Day, Year)
•	10+1							D57	7028			Augu	st 4,	2004
	[]			who completed cause							7			
	Contract of the last		Adit a C 31. Date filod (Month, Day Year,				Ave	nue	#23	l Ar	nna oli	s MD	21401	
	Sta Registr		AUG 0 5	2004	ristrar's Signa	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Spor	h						

			1 - State Registrar		artment of Health and rtificate of Death		ene . n2 0 0 4	25448
	Dhysisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month		3. Time of Death
	Physici /Medic		Edward Lee Love			August	3, 2004 Year	7:19 P M
	Examin		4a. Fecility Name (If not institution, give street and	number)	4b. City, Town, or Location of Deat	h	4c. County of Death	
			Holy Cross Hospital		Silver Spring		Montgome	ry
	Funeral		5. Social Security Number 164-60-4972 6. Sex	7. Age (In yrs. last birthday) 40 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		(ear) 9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	40 115.		May 14,	1964 New	York
	land		10a. State 10b. County	10c. City, Town or Lo	ocation		1	0d. Inside City Limits
	Mary -f sh	to	MD Montgomery	Silver S	nrino			X□Yes 2□No
	r 28a	rec	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cour	itry?
	h with	O E	686 Concerto Lane		20901		United Stat	•
	deat	ner	11. Marital Status 12. Was D	ecedent Ever in U.S. 13.\ Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - Americ	an Indian,
ဖွ	or Ite	교	1 ☐ Never Married 2 A Married 1 ☐ Ye	s 2 ANO	i res, specify Cuban, mexican, Puen 1 ☐ Yes 2 🛣 No Specify:	o Rican, etc.)	Black, White,	
8	ural',	d b		Give r Dates:	TET 163 ZEMANO Specilly.		African A	American
<u>v</u>	"nati	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade complete	d) 16a. Deced	dent's Usual Occupation kind of work done during most of woi DO NOT use retired)	rking 16	b. Kind of Business/Inc	lustry
2	withly ane. than	m du	Elementary/Secondary (0-12) College 4	1 1-40r 3+1	nical Engineer		.C. Govern	nont.
2 2	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural; or Items 23a or 28a-f show ant, the Medical Exame at must ten notified at	ပ္တိ	17. Father's Name (First, Middle, Last)	Hechai		ne (First, Middle, Ma		lle II C
Maryland 21215-0036	d be ental ced o	To Be	Johnnie Love			Coleman	den dumame,	
<u>Z</u>	shou nd M mar	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or Ru		tity or Town State Zin	Code)
Š	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inmportant: If them 27 is marked other than "natural; or Items 28a or 28a-f show any injury or other treumatic event, the Medical Examination at all once.	Ì	Lisa P. Love		Concerto Lane, Si			
ē,	ts 1 and 1 term of Hein other		20a. Method of Disposition	20b. Place of Dispo-	sition (Name of natory or other place)		c. Location - City or To	
Ë	Page In The Page		1 Burial 2 ☐ Cremation 3 ☐ Removal fro	Gate of H		/04 Si	llver Sprin	o. MD
Baltimore,	mit. partn ports y inju		21. Signature of Funeral Service Licensee	/ 22	. Name and Address of FacilitMcG		al Service	9, 112
<u> </u>	88 E 29		Undre Thomps		7400 Georgia Ave.			
	certificate be executed displaying physician and vide as the burial-transit	I Examiner	Cause (Disease or injury that initiated events c.	i each line.	hic Lateral			Approximate Interval Between Onset and Death
8760,	physic the b	dlcal	d					
ă j	death e atter id for u	Physician/Me	in the past 12 months?	gnant at time of death 5	Ectopic pregnancy Other <i>(specify)</i>		23d. Date of deliver Month	y Day Year
S,	i he taw requires that the ite has been signed by th age 2 should be detache	by P	Part II. Dther significant conditions contributing to	death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	cause of death?
ğ	w require been sig					1 🗌 Yes	2 □ No 3 □ Proba	ibly 4 🖃 thknown
ပ္မ	as be	Completed	9			24a. Was an		sy findings available
	0 4	Son				autopsy performed 1 Yes 2	death?	pletion of cause of
<u> </u>	clen: ertific ector,	Be (25. Was case referred to medical examiner?			th (Check only one)		
0	y till a	ပ	1 Tyes 2 No Hospital: 1	Inpatient 2 ER/Outpatient		ome 5 Residence	e 6 □Other (Specify)	
	After funer	on	1 Natural 5 ☐ Pending (Me	se of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in	njury occurred	
Division	or Attending ifter death. Director: After in by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	as of laive. At home form the	M 1 Yes 2 No	201 1 101		
<u>≥</u> `	after Direct	ertification:	4 Homicide determined 289. Pla	ce of Injury - At home, farm, stre Iding, etc. (Specify)	eel, factory, office	City or Town, Si	t and Number or Rural tate)	Houte Number,
-	purs eral eral	O	29a. Certifier 1 Certifying Physician: To	he best of my knowledge, death	occurred at the time, date and place,	and due to the cause	a(s) and manner as sta	tod
2	vithin 24 ho within 24 ho To the Fun completely i	edical	(Cricca Chair 2 medical Examiner: On the	basis of examination and/or invanner stated.	estigation, in my opinion, death occur	red at the time, date	and place, and due to t	the cause(s)
3	vithin 2 To the complet	ž	29b. Signature and title of certifier		29c. License number		Date signed (Month, D	ay, Year)
A	3 5 8		116					
			E -		D 052586	A	ugust 5, 20	004
	7 ⁹		30. Name and address of person who completed ca Patel Jayant,					

			1 - For State Registrar	Sta	ate of M	aryland .		artmeni rtificate				lental H	ygien Reg. N	200		251.1.9
	Dhuais		1. Decedent's Name (First, Midd	fle, Last)								2. Date of D	eath		*7 1	3. Time of Death
	Physic /Medi		MOLLIE	M.	LUTS		_					JULY	28,	^{ay} 2004	Year	5:40 P M
4	Exami	ner	4a. Facility Name (If not institution							Location of	of Death		4	c. County of	Death	
			CASEY HOUSE — 5. Social Security Number	MONTGO 6. Sex		OSPICE	hirthdayl	ROCK If Under	VILI	If Under	24 Hrs	0.5.4.45		MONTG		
	Funeral Director		577-10-7453	1 □ M 2		94	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D	av. Year	909 W	9. Birthpi Co <i>unt</i> JASHT	ace (State or Foreign lry) NGTON, DC
	p ,		Usual Residence of Decedent									001. 1	, ,	200	710111	INGIGIN, 20
	show	ō	10a. State 10b. Count			10c. City, T									10	od. Inside City Limits 1 No 1 No
	the Ma	Director	MARYLAND MONTO	SOMERY		N. B	ETHES	SDA 10f. Zip	Codo				10- 0	145		
	23a or		10404 STRATHMOR	E PARK	СТ. #	303			2085:	2				itizen of Wh	at Count	ry /
	ter deat	Funerai	11. Marital Status	12. W	as Decedent med Forces?	Ever in U.S.	13. V				gin? (Spe	ecify Yes or N Rican, etc.)		14. Race -	America	ın Indian,
36	ours after death with the Maryla ral', or tiems 23a or 28a-f shov Examiner met be molffice at	by Fu	1 Never Married 2 Mar	ried 1 [∃Yes 2∭Xi Yes, Give			Yes 2		Specify:	, Puerto	Hican, etc.)			White, e	tc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Madical Examirer mat be mutified at		3 X Widowed 4 □ Divorce	t's Education	ar or Dates:									Specify:		ITE
15	n "na Nadic	Completed	(Specify only highe	st grade com,			(Giva	ent's Usual kind of worl OO NOT us	k done di	uring most	of worki	ng	16b. F	Kind of Busi	ness/Ind	ustry
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pu	be filed within 72 hours aft ital Hygiene. Ind other then "naturel", or event, Ire Medical Exami	Be (17. Father's Name (First, Middle,	Last)						18. Mothe	r's Name	(First, Middle	, Maider	n Sumame)		
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Ma		1	19a. Informant's Name/Relation:		*							I Route Numb				20852
ē,	s 1 and 2 f Health item 27 I		20a. Method of Disposition			20b. Place	of Dispos	ition (Nam	e of	1		ate		ocation - Ci		
altimore,	Page Int: #		1 X Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (5	3 □Remova Specify)	al from State			atory or oth		´ 1	/30	2004		LPHI,	77	
Balt	permit. Pages. Department of H Important: If ite any injury or or		21. Signature of Funeral Service	Licensee	١							MEMOR	FAT 4	OHADDI	THAN	TNO
	40 E 8 9	W. 9	Donald (بر . '	Total	inye		I/U K	OCKV		PIK	E, ROCI	CATPI	LE, MI	20	1NG. 0852
п			23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final	only one cau	s that caused se on each lir	the death. D	o not ente	r the mode	of dying,	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician /Medical	8	disease or condition resulting in death)		EUMONI											Oliset and Death
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8760,	cate be executed physician and the burial-transit		tooning in oodin, and	1	Due to (or as	a consequenc	e of):									
687	ficate p phys is the	edical		d												
Box	death certifica e attending pla d for use as t	M/u	IF FEMALE: 23b. Was decedent pregnant		es, outcome									23d. Date o	f deliver	,
). B	deat	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4		2 Fetal dea time of death		Ectopic pred Other (spec						Month		ay Year
P.0	that the de ed by the detached	Phy	9 Unknown													
ds,	es bed	l by	Part II. Other significant condition	ons contribution	ig to death bi	it not resulting	in the und	derlying cau	uevig eau	in Part I.						cause of death?
Sor	> 40	etec											Yes 2	7	Probab	
$\mathbf{\alpha}$	The law ate has b page 2 st	Completed										24a. Was autop	osy	prior	r to comp	y findings available detion of cause of
	iician: Th certificate rector, pag	0	25. Was case referred to medica							26 Place	of Death	1 ☐ Yes (Check only o	rmed? 2 No	1 🗆	Yes 2	□ No
of <	si si	To B	examiner? 1 ☐ Yes 2 X No	Hospital	1 ☐ Inpatie	nt 2 ER/C	Outpatient	3□ DOA	Othor			e 5 Resi		6 XOther (Specif	OSPICE
	ing Ph	inol	27. Manner of Death 1 X Natural 5 ☐ Pendin	g	Date of Injur (Month, Day	Year) 28b	Time of Injury	- 1	. Injury a Work?			8d. Describe I	now injur	y occurred		
Division	or Attending P after death. I Director: After t d in by the funera	icat	2 Accident investig	not be	Place of Inju	ıry - At home,	fo.== -1	M	77.7	s 2□N		04 1				
	after after Dire	Certification;	4 Homicide determ	ined 200.	building, etc	. (Specify)	iaim, stree	et, ractory, o	опісе		2	City or Tox	vn, State	d Number o)	r Hural F	Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician:	To the best o	f my knowled	ge, death o	occurred at	the time,	, date and	place, ar	nd due to the	cause(s)	and manne	r as state	ed.
	To the H within 24 To the Fi complete	ledicai	one)	and	the basis of d manner stat	examination a	nd/or inve	stigation, ir	n my opin	ion, death	occurre	d at the time,	date and	place, and	due to th	ne cause(s)
	with con	Σ	29b. Signature and title of certifie	from	0	i M	(1)		License r				29d. Dat	e signed (M	lonth, Da	y, Year)
7	10	-	30 Name and address of source	7		acth (lt 00	J.		-2766	50			JULY	29,	2004	
			30. Name and address of person ALPANA GOSWAMI					,	, RO	CKVII.	LE.	MD 20	852			
	Sta	100	31. Date filed (Month, Day, Year)		32. Registra	r's Signature	4		M							
	Registra	ar	AUG 0 5	2004	pene	1		papa								

16		1. Decedent's Name (First, Middle, Last)	Frod	Lieb, S	Gr.		2. Date of 0 Month	Death Da	y Yeer	3. Time of Death
hysicia Medic/			rreu	птел, г			July	30	2004	0700 A
Examin	er	4a. Facility Name (If not institution, give s				, or Location of De	ath		. County of Dea	
		24 Sylvia Circle 5. Social Security Number 6. Sex		In yrs. last birthday)	Thurn		drs 0 Date of 5			ck County
uneral rector			M 2□F	92 Yrs.	Months Day		lin. (Month, I			thplace (State or Forei buntry) Many
rector		Usual Residence of Decedent					Tourie	97 19	GCI	marry
Mow I		10a. State 10b. County		0c. City, Town or Lo						10d. Inside City Limi
iffed	cto	Maryland Frederic	ck County	Thurmont				1		1 ☐ Yes 2 💢 N
rai, or items 23a or 28a-f ehow Examinar must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Co	ountry?
s 23a	<u>ra</u>	24 Sylvia Circle				788	/Coordy Vos or b		ed Stat	
ttem.	une	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No	er in U.S. 13.	If Yes, specify Co	iban, Mexican, Pu	(Specify Yes or to Jerto Rican, etc.)	NO-	Black, Whit	e, etc.
, o	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2XIN	o Specify:		1	Specify: Wh	ite
Item 27 is marked other than "natural", other traumatic event, the Medical Exp	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occ	upation ne during most of	working	16b. K	ind of Business	/Industry
W	ple	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use reti	red)	working			
£ 4	Completed	6		fai	mer	1			ricultu	re
d other	Be	17. Father's Name (First, Middle, Last)					Name (First, Midd	le, Maiden	Sumame)	
arked o	은	John Lieb					Miller			
raum.		19a. Informant's Name/Relationship (Ty					Rural Route Nurr			
em 27 ther tr		Myra Miller / daug	liter	20b. Place of Dispo	/lvia Ci	1	hurmont,	-	Tand 21 ocation - City or	
Important: If item any injury or othe once.		1 XBurial 2 ☐ Cremation 3 ☐ R		cemetery, cre Keysvill	matory or other p	^{lace)} Ju	11y 31		ymar, Ma	
Important: If II any injury or o once.	1	*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		_			2004 Skiles Fu	-		
any in		10. 6	2) '				e Street			n, MD 2178
sician and edical sthe prival transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	luy	- v			.4	14 days
igned by the attending phys be detached for use as the	Physiclan/Medical	in the past 12 months? 1 Yes 2 No 9 Unknown	d. 23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal déath 3[me of death 5[□Ectopic pregnal □ Other (specify)				23d. Date of de Month	Day Year
been signed should be de		Part II. Other significant conditions con	chg	not resulting in the u	inderlying cause	given in Part I.			.7	the cause of death?
has Je 2	Completed by	Parkingson	-'1				24a. Wt au pe 1 \(\text{Yes}	topsy rformed?	death?	utopsy findings availa completion of cause of 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?	(h-l-		1,		Death (Check only	y one)		
this c al dire	2	I Tes ZANO	Hospital: 1 Inpatient		III JU DON		g Home 5X Re			cify)
After funer	tlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	٧	vork? ☐ Yes 2 ☐ No	28d. Describ	e now mju	ry occurred	
irector: An on by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, office	ce	28f. Location City or 7	(Street ar own, State	nd Number or Ri	ural Route Number,
D D	edical (29a. Certifier 1	sician: To the best of iner: On the basis of e and manner state	xamination and/or in	th occurred at the ovestigation, in m	time, date and pl y opinion, death o	ace, and due to the courred at the time	e cause(s e, date an) and manner as d place, and due	s stated. to the cause(s)
e Funeral D		1 00h Cignoture and title of certifier #	0		29c. Lice	ense number		29d. Da	te signed (Mont	h, Day, Year)
To the Funeral Director: After this completely filled in by the funeral di	Me	29b. Signature and title of certifier	()			\sim				
To the Funeral Director: A completely filled in by the fu		signature and the original state of the stat	ww		/	22210	١	Oct	2 30	104

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:20 AM JULY **EDWARD** 2004 J. MULDOWNEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY BETHESDA 10401 GROSVENOR PL. #802 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR. 11,1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1**▼**M 2□ F Yrs. PA. 68 Director 203-28-6496 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-1 show of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic avent, the Medical Examinar must be notified at 1X Yes 2 □ No Funeral Director **BETHESDA** MD. MONTGOMERY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 10401 GROSVENOR PL. #802 20852 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be lited within 72 hours after 1X Yes 2 No 1954-If Yes, Give 1954-Year or Dates: 1957 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ 3 Widowed 4 Divorced WHITE 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONTRACTING OFFICER MONTGOMERY CO. GOV'T. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **JAMES** FRANCIS MULDOWNEY MARY CURRAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL J. DUDA/NEPHEW 3103 NESTLEWOOD DR., HERNDON, VA. 20171 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of H
Importent: If itel
any injury or ott 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 7-27-2004 RIVERDALE, MD. 4 Donation 21. Signature of Funeral Service Lansee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER CHRONIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discass of Injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. nding physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached t 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? page 2 t 2[] No 2**X** No 1 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Cther: 4 ☐ Nursing Home Hospital: 1 Yes 2 X ome 5 Residence 6 Other (Specify)
28d. Describe how injury occurred 1 Inpatient 2 ER/Outpatient 3 DOA this : After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending investigation after death.

Director: Aft 1 Tes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and tills of per JULY 27, 2004 D53177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER DR., ROCKVILLE, MD. 20850 JOHN M. WALLMARK, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 28 Registrar

			1 - For State Registrer	State of N	•	epartment o		nd Mental Hy	giene	251.52
	Physici /Medic		Decedent's Name (First, Middle, La George Joseph Mou					2. Date of Dea Month July 2	Day Yea	3. Time of Death
	Examir		4a. Facility Name (If not institution, given 18001 Hollingswood)	e street and numbe	er)	4b. City, Tow Derw	vn, or Location of	Death	4c. County of De	ath
	Funeral Director		219-03-2944	Sex 7 MM 2□ F	Age <i>(In yrs. last birtho</i> 82 ^{Yr}	Months Da	ear If Under 24 ays Hours	4 Hrs. 8. Date of Birt. (Month, Day Aug. 1,	h 9. B	irthplace (State or Foreign Country) ennsylvania
	show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	with tha M a or 28a-f	Direct	Maryland Montgome		Rockvil	10f. Zip Co			10g. Citizen of What (Country?
920	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, the Modical Excultational the motified at	by Funeral Director	18001 Hollingswol 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede	□Nº World	208 13. Was Decedent If Yes, specify 1 Yes 2 X	of Hispanic Origi Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	Specify: _	nerican Indian,
Maryland 21215-0036	- 10	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		or 5+)	ecedent's Usual O Give kind of work d fe. DO NOT use re ultry Sc	one during most o etired)	of working	16b. Kind of Busines United Stat	
yland 2	2 should be filed withir and Mental Hygiene. Is markad other than aumatic event, the M	To Be C	17. Father's Name (First, Middle, Last Joseph Henry Mou	intney			18. Mother's	s Name <i>(First, Middle,</i>	Maiden Sumame) d Itterly	
Baltimore, Mary	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ence.		19a. Informant's Name/Relationship (Vivian E. Mountr 20a. Method of Disposition 1	ey/Wife Removal from Sta	18 20b. Place of D commetery, Montgo Cremat	001 Holls isposition (Name of crematory or other mery orium, In 22. Name and A	ingswort	uly 31,	Dckville, 1 20c. Location - City of Bethesda	Maryland 20855 Maryland Funeral Home/
8760,	Pnysician /Medical Examiner	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Mali Due to (or any or any	ed the death. Do not	enter the mode of thelioma				Approximate Interval Between Onset and Death LessThan 6 Mos
.O. Box 687	The law requires that the death certificate be exacuted the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death at time of death	3 ☐ Ectopic pregn 5 ☐ Other (specify			23d. Date of do	elivery Day Year
Ω_	quires that t n signed by uld be deta	by	Part II. Other significant conditions of	contributing to death	but not resulting in the	ne underlying cause	a given in Part I.			to the cause of death? Probably 4 Unknown
Il Records,		Completed						24a. Was a autop: perfor 1 \(\text{ Yes} \)	sy prior to med? death?	
on of Vital	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpa 28a. Date of Ir (Month, I		ne of 28c.	Othor			ecify)
Division	al or Attendi after death. I Director; A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of	Injury - At home, farm etc. <i>(Specify)</i>	, street, factory, off	fice	28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital or Attens within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1	nysician: To the be niner: On the basis and manner	of examination and/o	leath occurred at the printer investigation, in r	ne time, date and my opinion, death	place, and due to the c occurred at the time, d	ause(s) and manner a late and place, and du	is stated. le to the cause(s)
		Σ	29b. Signature and title of certifier Par J - Bo				cense number		29d. Date signed (Mon	
6	(0 +1		30. Name and address of person who Payl Bannen	completed cause o	f death (Item 23a) (Ty	rpe, Print)	e #32	7, Olacy	MODE	2832
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signature	Sport	h	1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year John McNabb L. 6:15P July 25, 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Montgomery 3330 N. Leisureworld Boulevard, #724 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) April 19,1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Illinois **№** M 2 F 73 358-22-1562 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Silver Spring Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 3330 N. Leisureworld Blvd., #724 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Folces; 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: WW— II 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electric 12 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sr. Mary Billington John L. McNabb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. McNabb, Son 104 Mayfair Drive N.E., Leesburg, VA 20176 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory July Alexandria, Virginia 22. Name and Address of Facility 27, 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee Donald V. Borgwardt Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, App. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Heart Disease Due to (or as a consequence of): Hypertension Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury Diabetes Mellitus Type II that initiated events resulting in death) Last Due to (or as a consequence of): Dyslipidemia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred

Examiner requires that the death certificate be executed burial-transit and P.O. Box 68760 attending physician as the use ŏ signed by the a Division of Vital Records, should be peeu certificate has or Attending Physicien:

Physician

/Medical

Examiner

Funeral

Director

or 28e-f show

or Items 23a

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permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "n any injury or other treumatic event, Its Modits once.

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Examiner

within 72 hours after

Baltimore, Maryland 21215-0036

Director

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Physician/Medical Certification:

after death. within 24 hours a To the Hospitel

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Medical (Check only one) 29b. Signature and title of certifier

1 XNaturai

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifior

determined

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

138802

29c. License number

1 Scarnitying Physician. To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Dav. Year) 26104

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Osvaldo M. Gonzalez, 8830 Cameron St., #402 Silver Spring, MD M.D. 31. Date filed (Month, Day, Year)

State Registrar

JUL 29 2004 32. Registrar's Signature

Jacks

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Physicia	*	Registrar Amend#10e, 1. Decedent's Name (First, Middle, Las	t)		•	TITICATE OF	Death	2. Date of De	Reg. No.	Year	3. Time of Death
/Medica	al .	JAMES AL			, JR.			June	Day 27	2004	12:55 P M
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00	3	5. Social Security Number 6. Sec		7. Age (In yrs.	last hirthday)	Galest	If Under 24 Hr	s. 8. Date of Bir		chest	
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/lar/ wuld by Menta Ment	0	JAMES ALBER	T MASS	SEY, S	R•		CONST	ANCE AN	N STOK	ES	
- 12 miles		19a. Informant's Name/Relationship (7 JAMES A. MASSE		FATHE		g Address (Street a					
Baltimore, M permit. Pages 1 and 2 Department of Health a Importent: if them 27 is any Injury or other tre		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify		State EA	STOSH	sition (Name of ORTER other plac ORTUM	6/30	Date 0/04	20c. Location		
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/Medical Examiner		resulting in death)	Due to	(or as a consequ	uence of):						
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nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(0. 00 0 00.004)	20,100 01,					ļ	
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G. By deat	SICIB	in the past 12 months? 1 Yes 2 No		ant at time of de		Ectopic pregnancy Other <i>(specify)</i>			Mo	nth	Day Year
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Division or Attending after death. Director: After In by the fune	Certification:	4 Homicide determined	28e. Place	of Injury - At ho ng, etc. <i>(Specif</i> y	me, farm, stre ')	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n. State)	er or Rurai	Route Number,
spitel ours cours filled	<u> </u>	29a. Certifier 1 ☐ Certifying Phy	sicien: To the	hest of my know	wiedne death	occurred at the tim	e date and place	and due to the	anuca(s) and me		And .
e Hos	dical	(Check only 2 Medical Exem	iner: On the bi	asis of examinat ner stated.	ion and/or inv	estigation, in my op	inion, death occi	urred at the time, of	late and place,	and due to	the cause(s)
To th within To th	Z E	29b. Signature and title of certifier				29c. License	number	- 2	29d. Date signed	(Month, D	ay, Year)
		Y O Larke	eur)			(O.C.M.E.		June 28	, 200	4
		30. Name and address of person who c		e of death (Item		Print) Baltim	ore, Mar				
State	φ į	31. Date filed (Month, Day, Year) AUG 0 5 20	32. R	egistrar's Signat	ure &	Spork					
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			State Registrar			Cer	tificate of	Death		Reg. No.	004	2545	5
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J. C	es 1 and the color of He color of the color		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Re	mount from State		ace of Dispormetery, cren	sition (Name of natory or other pla	ice)	Date	20c. Lo	cation - City or	Town, State	
Ē	Page III Sub	100	'4 □ Donation 5 □ Other (Specify)	illoval ilolli State	CH	AMBER	S CREMAT	ORY 7-2	7-2004	RIV	ERDALE,	MD.	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a once.		21. Signature of Funeral Service User se	chence	2 _{M000}	C		ess of Facility FUNERAL ELAND AV					
	8		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that cause	d the death.						L, 11D.	Approximate Interval Between	an .
	Pnysician		Immediate Cause (Final disease or condition			י יייטעט	OID CANC	ED.				Onset and Dea	ath
	/Medical		resulting in death)	Due to (or as			JID CANO	LIK					
	Examiner		Sequentially list conditions										
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Exit of Underlying Causa (Disease or injury	Due to (or as	a consequ	ence of):							
	and trans	Exami	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as									
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	E		Due to (or as	a consequ	ence on).							
87	physi the t	dlcal	d.										
9 X	ding	/Me	IF FEMALE: 23	c. If yes, outcome	of pregnar	ncv	-10.00				23d. Date of deli	ven/	
Вох	leath certific attending p	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pregnand Other (specify) _	ÿ.		ľ	Month Month	Day Yea	ar
o.	by the datached	ysic	1 ☐ Yes 2 ☐ X yo 9 ☐ Unknown	9□ Unknown			(otiloi (opeony) _						
٩	that ned by deta		Part II. Other significant conditions con	ributing to death t	out not resu	lting in the ur	nderlying cause g	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of dea	ıth?
rds	quires n sign uld be	d by							1 🗆	Yes 2	□No 3□Pr	obably 4X\u00e4Unk	known
S	w requ	lete							24a. Wa		24b. Were au	topsy findings ava	ailable
Records,	The lav	Completed					-		auto perf	opsy formed? 20 No	death?	completion of caus	S9 01
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Į <	di is	To B	examiner? 1 ☐ Yes 2 ☐ XNo	ospital: 1 🛣 Inpati	ent 2 🗆 E	ER/Outpatien	t 3 DOA	her: 4 Nursing	Home 5 ☐ Res	idence 6	Other (Spec	cify)	
Jo u			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	28c. Inju	iry at ork?	28d. Describe	how injur	y occurred		
<u>0</u>	death. ctor: Al	atle	2 Accident investigation					Yes 2□No					
Division	or Attend after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At hor tc. (Specify	me, farm, str	eet, factory, office			(Street and own, State		ral Route Numbe	r,
_	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Phys										
	thin 2 the I	Medical	one) 29b. Signature and title of certifier	and manner st	tated.			se number			e signed (Montl		
)			Prode	JI)				231 (MA)		210	Que De	101	
	9+1		30. Name and address of person who col	moleted cause of	death (Itam	23a) (Type			NIATIAT NAT	TOTOA	Chymn.	D	
-			JENNIFER L. CROOK	LCDR N	4C US	SN	В	ETHESDA				N.	
PM	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUL 27 200	32. Pegist	rar's Signat	ure &	Spork				· · · · · · · · · · · · · · · · · · ·		

December December				1 - For State Registrar	State of	Maryla	nd / Depa	artmen rtificat				lental Hy	giene	200	September of the septem	251.56
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The force of the extraction of the medical state of the s				Todaking in douthy												
The initial military avenue is searched to the cause of the part o			e	Sequentially list conditions, if any leading to immediate	b. Sepsi	s wit	h Septi quanna of)	c Sho	ck						-	
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Spoon of the state	Bo	atten for u	cian	in the past 12 months?	1 ☐ Live birth	2 ☐ Fet	al death 3 🗆						2			
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25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1		as tha gned i	oy P					derlying ca	use giver	n in Part I.		23e. Did to	obacco us	se contribu	te to the	cause of death?
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Saima Khawaja, M.D. 11119 Rockville Pike, #100, Rockville, MD 20852 State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	<u>ح</u>	The cate h	Con									perfor	rmed?	deat	h?	_
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State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature	_								e, #	100,	Rock	ville,	MD	20852		
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			Decedent's Name (First, Middle, La	ist)			imout	01 2	Joann		2. Date of D		5-m	94	3. Time of Death
п	Physici		Harry Campbell M	anderson							July 2		2004	Year	4:55pm M
	/Medio Examir		4a. Facility Name (If not institution, given		ver)		4b. City,	Town, or	Location	of Death	July 2		lc. County	of Death	4:33pm
			Montgomery Villa	ge Care	& Reha	b Ctr.	Mon	toom	ery '	7111	906		Mont	gomer	37
	Funeral		Social Security Number 6.5	Sex 7.		last birthday)	If Under Months	1 Year	If Under		8. Date of B			9. Birthp	lace (State or Foreign
ь	Director		169-12-9281	1 ⊠ M 2□F	81	Yrs.	MORILIIS	Days	Hours	Min.	Apr.			Penn	sylvania
	D .		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	antion								
	eho oho	ក					cation							1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	tha N	Director	Maryland Montgom	ery	Roc	kville	104 7:-	0-4-				100	No.		
	with						10f. Zip							What Cour	•
	na 23	era	13602 Parkland D	12. Was Decede	ent Ever in II	S 13 1		853	nanic Ori	igin2 (Sp	acify Yes or N			Stat e - Americ	
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ehow any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Force 1 X Yes 2 If Yes, Give Year or Date	∍s? □ No	,	f Yes, spec	ify Cuban	Specify:	n, Puerto	Rican, etc.)	io-		ck, White,	etc.
ŏ	2 hou		15. Decedent's E	ducation	AAAA — T	16a. Deced	ient's Usua	I Occupa	tion			16b.	Kind of B	wn.	ite
215	nin 7.	Completed	(Specify only highest gri	ade completed) College (1-4	or Eu)	(Give	kind of won DO NOT us	k done di	urina mos	t of work	ing	100.	rana or B	2011103371110	203119
21	d with giens or the	mo:	7	College (1°4	01 3+)	En	grave	r				Je	ewelr	·y	
g	e fila al Hy loth vant	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle	e, Ma <i>id</i> e	n Suman	18)	
<u>a</u>	wild b Manta	To	Bucky	Manderso	า				Emn	na Ca	sidy				
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Address	(Street a			I Route Numi	ber, City	or Town,	State, Zip	Code)
	and salth m 27		David Samuelson	- frien		9104	Gosh	en Pa	ark F	lace	. Gait	hers	sburg	, MD	20882
altimore,	Fita I		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐	Removal from Sta		Place of Dispo semetery, cren	sition (Nam	e of			ate			City or To	
Ë	mant mant tant:		'4 □Donation 5 □ Other (Special		I	ropoli	tan C	rema	tory	7-30	0-04	Ale	xand:	ria,	Virginia
Ball	apari npor ny in nce.		21. Signature of Funeral Service Licer	ISBO	20	1.0	. Name and	Address	of Facilit	y De	Vol Fu	nera	1 Ho	me	
	0.07 % OI		Yolert X	Heling		Gă	East	sbur	g, M	b 20	877 ^e				
I.			23a. Part1. Enter the disease of com slock, or eart failure. List only	one cause on e	sed the deat h line.	h. Do not enti	er the mode	of dying,	, such as	cardiac o	r respiratory a	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			Heart I	ailur	:e							Onset and Death
	/Medical Examiner		Toolston and assettly	,	as a conseq	,									
E		-	Sequentially list conditions, if any, leading to immediate		ry Art	tery Di	isease	9							
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Вох	that the death cartif ad by the attending datachad for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor									23d. Dat	e of delive	rv.
ă	daath e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth	at time of de		Ectopic pre Other (spe						Mor		Day Year
P.O.	t the by th	hys	9 Unknown	9□ Unknowr	1										
	as tha ignad ba dal	by P	Part II. Other significant conditions of	ontributing to deat	n but not rest	ulting in the un	derlying car	use given	in Part I.		23e. Did	tobacco	use contr	ibute to the	a cause of death?
ğ	w raquirg been sig	ed									1 🗆	Ye <i>s</i> 2	! □ No	3 🗌 Proba	abiy 4 🛮 Unknown
ecc	law ra as be 2 sh	pie									24a. Was		24b. V	Vere autop	sy findings available
ď		Completed										psy ormed? 2 ⊠ No	d	eath?	pletion of cause of
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<u></u>	Physic this ca	2	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatient	3□ DOA	Other	4 🕱 Nur	rsing Hon	ne 5 🗆 Re <i>s</i> i	dence	6 Othe	or (Specify)	
ם	Attanding Physician: Ir daath. actor: Aftar this cartifici by tha funaral director.	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of II	njury Day Year)	28b. Time of Injury	28	c. Injury a Work?	ıt	2	8d. Describe	how inju	ry occurre	ed	
<u>sio</u>		cati	2 Accident investigation 3 Suicide 6 Could not be				М	1 🗀 Ye	s 2 🗆 N	No					
Division of Vital Records,	tal or Attan rs after daat al Diractor: ad in by tha	Certification	4 Homicide determined	288. Place of	Injury - At ho etc. <i>(Specif</i> y	me, farm, stre	et, factory,	office		2	8f. Location (City or To	Street al wn, State	nd Numbe a)	or Rural	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completally fillad in by	edicai	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 ★ Medical Example 1	ysician: To the be niner: On the basis and manner	of examinat	wledge, death ion and/or inv	occurred at estigation, i	t the time n my opir	, date and nion, deat	i place, a h occurre	nd due to the d at the time,	cause(s date and) and mar d place, a	nner as sta nd due to t	ted. the cause(s)
		Ž	29b. Signature and title of certifier	znt"			29c.	License r	number			29d. Da	te signed	(Month, D	ay, Year)
	10+1		Mind G				D	411	62			Jul	v 29	, 200	4
			30. Name and address of person who	completed cause o	f death (Item	23а) (Туре, Р							<i></i>	, 200	
			Vinu Ganti, MD 91				, Gai	ther	sbur	g, M	20882	2			
	Stat Registra	-	31. Date filed (Month, Day, Year)	32. Regi	strar's Signat	ure g	Spa	cks	/						

			State of Maryland / Departme	ent of Health and Mate of Death		2001	251.50
			Registrar 1. Decedent's Name (First, Middle, Last)	ne or bearing	2. Date of Dea	ith	3. Time of Death
_	Physici		CALVIN SPRINGFIELD MARTIN		AUGUST	Day Year 2004	11:00 A M
	/Medic Examir			ty, Town, or Location of Death	1100001	4c. County of Deetl	
	LXaiiii		FAHRNEY-KEEDY NURSING HOME BC	OONSBORO		WASHINGTO	ON
	Funeral		5. 555 at 5. 555	der 1 Year If Under 24 Hrs. Is Days Hours Min.	8. Date of Birth (Month, Day March 2	9. Birth	nplace (State or Foreign untry)
	Director		57 9 18 038 9 12 m 2 l r 85 Yrs.	J Days House Min.	March 2	1 1919 Was	hington,D.C
	pur *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aarylis f sho	ō					1 ☐ Yes 2 No
	h the Marylan r 28a-f show Lnotllied at	Director	Md. Frederick Myersville	Zip Code		10g. Citizen of What Cou	untry?
	th with 23a or ust be	ā	2726 Canada Hill Road	21773		United Sta	•
	urs after death with the Maryland et, or items 23a or 28a-f show Exeminer must be mailified at	Funerai		cedent of Hispanic Origin? (Spi pecify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	ican Indian,
9	5 P E	Ē	1 Never Married 2 Married 1 XYes 2 No	2 No Specify:	Hican, etc.)		o, etc.
93	ours	d by	3 Widowed 4 Divorced Year or Dates: WWII	2 NO Specity.		Specify:	White
2-6	within 72 hours after ene. than "naturel", or ite he Medical Examina	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us (Give kind of life. DO NOT	work done during most of work	ring	16b. Kind of Business/li	ndustry
12	within ene. then	E C	Elementary/Secondary (0-12) College (1-4or 5+) 12 Administ	· · · · · · · · · · · · · · · · · · ·		County Heal	lth Dont
D 0	be filed within 75 ntal Hygiene. Ind other than "in event, the Med	ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle,		ith bept.
/Jan	2 should be filed with and Mental Hygiene is marked other that aumatic event, the	To Be	Oscar C. Martin	Barbara	L.	Beuchert	
Baltimore, Maryland 21215-0036	id 2 should tth and Men 27 is marke traumatic			ess (Street and Number or Run nada Hill Road			ip Code) 21773
ē,	of Health Item 27		20a. Method of Disposition 20b. Place of Disposition (N	lame of	Date	20c. Location - City or T	Town, State
e E	Pages nert of nr: # it		1 □ Burial 2 🕱 Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) Metropolitan		/ 04	Alexandria	, Virginia
alti	permit. Pages Department of Important: If it any injury or once.			and Address of Facility iel H. Barber			
m	88 5 8		Muriel So-Barker P. 0). Box 5038.	laytonsy	rille, Md. 2	20882
C			23a. Part1. Enter the distase, or complications that caused the death. Do not enter the meshock, or heart failure. List only one cause on each line.	ode of dying, such as cardiac	or respiratory arr		Approximate Intervat Between
	Physician		Immediate Cause (Final disease or condition	MY DISEC	ase	1	Onset and Death
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Cevebre versulting b.	Λ	dent		
7	Lxammer	_	Sequentially list conditions, b.	.44			
8	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1			
4.	ate be executed hysicien and the burial-transit	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):	1			
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S. 789			0.				
C X	leath certifica attending ph I for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	/ery
7 W	death e atte	icia	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (Month	Day Year
20	it the di by the tached	hys	9 ☐ Unknown				
S, F.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.		bacco use contribute to	
75	requir been s should	Completed			1 🗆 Y	es 2,⊠No 3 ☐ Pro	bably 4 Dunknown
	elaw hasb je2sl	npie			24a. Was a autops	sy prior to co	opsy findings available ompletion of cause of
<u> </u>	: The				1 Tes		2 No
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death			
of	Phys this ral dir	.T	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ 0 27. Manner of Death	4 Mursing Ho		ence 6 Other (Speci	ify)
u	ding F h. After funera	ţ	1 Natural 5 Pending (Month, Day Year) Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. Describe in	ow injury occurred	
Division of Vital R	or Attending Physician: after death. Director: After this certifics in by the funeral director, p	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor		28f. Location (Si	treet and Number or Rur	al Route Number,
οį	afor safter Direction	Certification;	4 Homicide determined building, etc. (Specify)	,	City or Town	n, State)	
	To the Hospital or At within 24 hours after of To the Funerel Direc completely filled in by	edical (29a. Certiflier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurre 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ed at the time, date and place, on, in my opinion, death occurr	and due to the cred at the time, d	ause(s) and manner as s ate and place, and due t	stated. to the cause(s)
_	To the within 2	Mec	and the more details.	29c. License number	2	9d. Date signed (Month,	Day, Year)
			I fain when	D0060396		08/01/0	4
	10 +1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-	1 1	,
				26 Opal Court,	Hagerst	own, Md. 2	21740
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	anks			
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		_	For State Registrar			Maryland		artment of rtificate of		and Mer		jiene 19. jkk. (104	254.59
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Ex	amine	r	4a. Facility Name (If not institut	ion, give	street and number	er)		4b. City, Town,	or Location o	f Death	7	4c. C	ounty of Death	า
			Doctors Hospi	tal				Lanhan				Pr	ince Ge	POTORS
Fun			5. Social Security Number	6. Se	x 7., ☐M 2 x F	Age (In yrs. la		If Under 1 Yea Months Day			Date of Birth (Month, Day		9. Birth	nplace (State or Foreig
Dire	ctor	-	577 20 3470		- X	90	Yrs.				ept. 1			ginia
and		-	Usual Residence of Decedent 10a. State 10b. Coun	ty		10c. City	, Town or Lo	cation						10d. Inside City Limit:
Aaryl I sho	명	5												1 ☐ Yes 2 No
the t	1	Director	Maryland Prin 10e. Street and Number	ce_G	eorges	Se	abroo	10f. Zip Code				0.000		
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E ag a p	ic e		Wilbur J. Si	e k										
Tarylal 2 should b and Mente is marked	tem.	-	19a. Informant's Name/Relation		ype, Print)		19b. Mailir	ng Address (Stree	t and Number	r or Rural Ro	Put	City or T	own State Zi	in Code)
and 2 and 2 ealth a n 27 is	Tre.	Ĭ	Ruth Ann Conti	r /	Daughter) Treela						
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ages ont of	1		1 Burial 2 Cremation			(0)	-	natory or other pl	· !				60.00	
Balfimore, permit. Pages 1 ar Department of Hea Important: if item	흩	ŀ	4 ☐ Donation 5 ☐ Other21. Signature of Funeral Signature	1		Nat	ional	Mem. Pa	rk 8	/7/200	041	Falls	Churc	h, Virgini
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		-	22d Posts Francisco	N	moscu		1	1800 New	Hamps	hire A	ve Si	lver	Spring	, MD 20904
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BOX 68 death certifical		บ –	IF FEMALE:									-		
. BOX 6 death certifi e attending I	or use		23b. Was decedent pregnant	2	23c. If yes, outcom 1□Live birth			Ectopic pregnanc	**			23d	. Date of deliv	ery
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as been signed by th	be de		Part II. Other significant condi				tting in the ur	nderlying cause g	ven in Part I.		23e. Did tob	acco use	contribute to t	he cause of death?
aquire en si	should	ב	Atrial	fu	wilation)					1 🗌 Ye	s 2 🗆 N	lo 3 ☐ Prot	bably 4 🗗 Unknown
Vital Hecords, sicien: The law requires to certificate has been signed.	2 sho	completed	Husut	Mic	britation						24a. Was ar	1 2	4b. Were auto	opsy findings available
The lav	page	5	1								autopsy perform	ned?	prior to co death?	mpletion of cause of
VITAL P VICION: Th Certificate	or, p	U	25. Was case referred to medic	al					OC Place		1 Yes 2		1 🗆 Yes	2PNo
OT VITA Physicien: this certifica	director,	2	examiner? 1 ☐ Yes 2 ☐ No	-	Hospital: 1 Inpa	tiont 2 🗆 🗆	R/Outpatien	t 3□ DOA Ot			neck only one			
Phys	<u>a</u> [- +-	27. Manner of Death	!	28a. Date of In	iury :	28b. Time of	OLI DOX	4 🗆 14013		Describe ho		Other (Specif	(y)
On on other	fuo fuo	5	1 Natural 5 Pend 2 Accident inves	ing tigation	(Month, E	Jay Year)	Injury	28c. Inju Wo	rk?]Yes 2∐N				5541104	
i or Attending after death. Director: After	ed in by the funera	2	3 ☐ Suicide 6 ☐ Coul		28e. Place of I	niury - At hon	ne, farm, stre	et, lactory, office			ocation /Str	eet and N	umber or Rus	al Route Number.
after Dire	in b	5	4 Homicide	mined	building,	etc. (Specify)		, , , , , , , , , , , , , , , , , , ,			City or Town,	State)	ornoor or mure	ar mode rearriber,
the Hospital of thin 24 hours at the Funeret D			29a. Certifier 1 Certify	ing Phy	sician: To the bes	at of my know	ledge death	Occurred at the t	ime date and	place sed	due to the a	(100/5)	d mars ::	****
24 h	pletely fil	٥	(Check only 2 Medica one)	I Exami	ner: On the basis and manner	or examination	on and/or inv	estigation, in my	opinion, death	occurred at	t the time, da	use(s) and te and pla	u manner as s ice, and due to	the cause(s)
To the within 2	эмр		29b. Signature and title of certif		- IV maindi	- arod.		29c. Licen					gned (Month,	
F 3 F	ğ		Rointon		a hut	Mn		7) 4711	/		8	426	
7						1 1)			1 344	6		3	7.07	
			30. Name and address of perso		empleted cause of	death (Item :	23a) (Type, I	Print)	. A	cuit ?	-61 -	1		40 20902
	0.		31. Date filed (Month, Day, Yea		HIF AR	rade Simon	780	George	n sive ?	,,,,,	-41 Si	war 5	pring	40 20902
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MBy E, LAMIN 220-08-0727 Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760.

PI	ease Type or Pri	nt in Black In	delible lnk. Ensure Al	l Copies Ar	e l egible	
			artment of Health and M			
1 - For State Registrar	0.0.0 01 11		rtificate of Death	, ,	2001	05160
Decedent's Name (First, M.	iddle, Last)		Timodic of Death	Reg. I	Nø.	3. Time of Death
		241		Month, I	Day Year	
Lamin 4a. Facility Name (If not instit.	Abdou	Mbye			30 2004	1340 M
		/	4b. City, Town, or Location of Death	•	4c. County of Death	
5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	0.5.4 (5)		
220 - 08 - 0727 Usual Residence of Deceden	1 ⅓ M 2□F	7 0 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 03/03/3/	ar) Countr	
10a. State 10b. Co.		10c. City, Town or Lo	ocation		100	d Inside City Limits
	comico	Salisbu			10	d. Inside City Limits
		3411304				1 ☐ Yes 2 🔀 No
10e. Street and Number	· 1 - D 1		10f. Zip Code		Citizen of What Countr	y?
704 Rivers	ide Rd.		21801	l (J.S.A.	
11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Black, White, et	
1 Never Married 2 🕅 1	If Yes Give	No	1 ☐ Yes 2 ☑ No Specify:	110011, 0(0.)	Specify: Black	
3 Widowed 4 Divor	ced Year or Dates:		- 2 103 2 A 110 Speciny.		Specify: DIa	- K
15. Dece (Specify only hi	dent's Education ghest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of working		Kind of Business/Indu	,
Elementary/Secondary (0-1	2) College (1-4or	life.	DO NOT use retired)		ducation	Easterr d. Shore
	5+	Asso	ciate Professo	r Un	iv. of Mo	1. Shore
Abdou W		bуе	18. Mother's Name Fatou	(First, Middle, Maid Jagn		
19a. Informant's Name/Relati	onship (Type, Print)	19b. Mailir	ng Address (Street and Number or Rura	I Route Number, City	v or Town. State. Zin C	Code)
Isatou Mbye	/ wife		Riverside Rd.,			21801
20a. Method of Disposition		20b. Place of Dispo			Location - City or Town	
	on 3 Removal from State	Family	Cemetery 8/05			,
' 4 ☐ Donation 5 ☐ Othe 21. Signature Funeral Serv	1 1	_	J		njul, Ga	
21. Signature of Funeral Serv	ICE (ICENSEE)		Name and Address of Facility Un 11 Kennedy St.,			20011 D.C.
23a. Part 1. Enter the direase	or complications that cause ist only one cause on each I	the death. Do not ent	er the mode of dying, such as cardiac o	r respiratory arrest,	A	pproximate
Immediate Cause (Final disease or condition resulting in death)	-a. Jeg	Pho	Shock			nterval Between Onset and Death
	Due to (or as	a consequence of):	15-16-6	00 0		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	prospale	Carry S		
Cause (Disease or injury	*		-			
that initiated events resulting in death) Last	c Due to (or as	a consequence of):				
	d					
IF FEMALE:						
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Da	
Part II. Other significant cong	tions contributing to death	aynot resulting in the ur	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
Diaset	er mel	47		1 ☐ Yes	2⊠No 3∏Probab	ty 4 □Unknown
				24a. Was an	24b. Were autons	/ findings available
				autopsy performed?	24b. Were autopsy prior to comp death?	letion of cause of
25 Was case referred to	inal			1 ☐ Yes 2 N		□No
25. Was case referred to med examiner?	11		26. Place of Death			
1 ☐ Yes 2 XNo	Hospital: 1 Inpatie	ent 2 ER/Outpatient	1 3 □ DOA Other: 4 □ Nursing Hom	e 5 🗆 Residence	6 ☐Other (Specify)	

/Medical **Examiner** The law requires that the death certificate be executed Note Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Completed by Physician/Medical

this certificate has

Be

2

Certification:

Medical

To the Hospitel or Attending Physicien:

within 24 hours after death. To the Funerel Director: After

10

Physician

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23s or 28s-1 show any injury or other traumatic event, it's Modical Examinational periodified at 2008.

Funeral Director

Completed by

Be (

25. Was case examiner? 1 Yes 2 No 27. Manner of Death 1. Natural

2 Accident

3 🗌 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Millerd DiNardo MD ILNATIUS

Print) Salisbuny Md. 21804 July 30, 2004

State Registrar

31. Date filed (Month, Day, Year) AUG 0 2 2004 32. Registrar's Signature

oaks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2004 P **Physician** 31 5:29 JOHN PERSHING MCCLEARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country)
 AZ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1⊠M 2□F 10-9-1918 Director 559-18-8669 85 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show ביימור: וו וופוח צל is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Ita Medical Exactinar must be notified at 8. • 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Director Washington D.C. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20008 U.S.A. #1327 3001 Veazey Terr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 257 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Gov't USAF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Mc Cleary Therese Moran 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Co 3001 Veazey Terr. #1327 Wash., D.C. 20008 19a. Informant's Name/Relationship (Type, Print, Gudrun Mc Cleary -Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 8-4-2004 Alexandria, VA Mt. Comfort Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jos. Gawler's Sons F. H. 5130 Wisconsin Ave. N.W. Wash., D.C. 20016 23a. Part1. Enter the disease, or complications that dayed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached to Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1☐ Yes 2X No To the Hospital or Attending Physician: After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) L_O 1 ☐ Yes 2X No 1X Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No nerel Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 22114 (AL) NATIONAL NAVAL MEDICAL CENTER d address of person who completed cause of death (Item 23a) (Type, Print) BETHESDA MD 20889-5600 JONATHAN C. GROH LCDR MC USN 31. Date filod (Month, Day, Year) 32. Registrar's Signature State 5 AUG 0 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

					State of IV	ai yiai		Certific				nerital Fly	Reg. Np.	04	25	163
H	Dhygiais		1. Decedent's Name	e (First, Middle, Le	est)							2. Date of Do Month	eeth Day	Yeer	3. Tin	ne of Death
	Physicia /Medic		Lenore		W.	M	[egle	n				Aug. 3	, 2004		2:0	OOP.M.
	Examin		4a Fecility Name (I	f not institution, giv	re street end number)				4b. City, To	wn, or L	ocation of Dear	th 4c. Cou	nty of Deeth	1	
			Manor Ca	re Chevy	Chase					Chevy				gomery	7	
	Funeral		5. Social Security N		Sex 7. A 1 □ M 2 □ F	ge (In yrs.		rs. If Un	nder 1 Year hs Days		24 Hrs. Min.	8. Date of Bi (Month, D Mar. 2	rth ay, Yeer)	9. Birth Col	nplace (St untry)	tete or Foreign
	Director		225-26- Usuel Residence of	9231	- X	88		15.				Mar. 2	1,1916	Vi	rgin	ia
	puel Ma		10a. Stete	10b. County		10c. Ci	ity, Town	or Location							10d. Insid	de City Limits
	Mary Firsh	호	D.C.	none		Wa	shir	ngton							1 🛮	Yes 2 □ No
	r 28e	9	10e. Street end Nur	mber		1			Zip Code				10g. Citizen	of Whet Co	untry?	
	h wit	0	2606 41st	t Street,	N.W. #	1		2	0007				U. S	S.A.		
	deat	ner	11. Marital Status		12. Was Decedent	Ever in L	J,S.			Hispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	o- 14. F	Race - Amer		ın,
Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Exprisher must be indiffed at ONGS.	To Be Completed by Funeral Director	1 ☐ Never Marri 3 ☐ Widowed	ed 2 Married	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:					Specify.		nican, etc.)		Black, White <i>city:</i> Wh	ite	
Õ	natur	ted	(Saas	15. Decedent's E			16a. l	Decedent's U	Isual Occup	pation	et of work	ina	16b. Kind o	f Business/I	ndustry	
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e,	Healt Healt Sm 27	1	20a. Method of Disc		len/Daught		L I	Disposition (in crematory of	LTCIO(Name of	ot Coi	irt I	Reston,	Virgin			to
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를	ortmen injury		4 ☐ Donation 21. Signature of Fu	5 ☐ Other (Specif	**	H18	gnia	nd Bur	ial P	ark ass of Facili	v Del	004 701 Fun	Danvil	le, V	irgi	nia
Ba	permit. P Depertme Importan any Injur		1	we Th	BOH			22.744.110		2222 Wash	Wisc	Vol Fun consin on, D.C	Ave. 2000	Ň.W.		
			23a. Part . Enter the shock, or hear	ne disease, or com rt failure. List only	plications that cause one cause on each I	d the deel	th. Do n	ot enter the n	node of dyir	ng, such as	cardiac	or respiratory a	rrest,		Approx Interva	imate I Between
	Physician														Onset a	and Death
	/Medical Examiner		Immediate Cause (disease or condition resulting in death)	Final n	a. Acute	Myoca	ardia	al Inf	arct					1	Immed	diate
		-	rosaking in south)					onsequence						1		
	red nsit	Ĕ			b. Corona		-			Hear	t Di	sease		1.	5 Yea	ırs
	exect n end iel-tra	Exa	Sequentially list cor if eny, leading to im cause. Enter Unde	nditions, mediate		Due to (d	or as a co	nsequence	Of):					1		
68760,	tificate be executed g physicien end es the buriel-transit	edical Examiner	that initiated events	injury	c	Due to (c	or as e co	nsequence o	of):							
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.O. Box	th cer endir r use	an.			d									1		
Ш	e dear	SICI	Pert II. Other eignifi	icant conditions o	ontributing to death t	out not res	ulting in	the underlyin	g cause giv	ven in Part I		23b. Did	tobacco use	contribute	to the car	uee of death?
<u>Ч</u>	law requires that the death cer as been signed by the attendir s 2 should be detached for use	Physician/M										1 🗆	Yes 2⊠N	o 3□Pre	obably	4 🗌 Unknown
Š,	ries the signe d be d	þ										04-14		04h W	Vara auto	nou findings
Ö	requi	etec										24a. was	an autopsy ormed?	a	vailable p	psy findings rior to n of cause
Records,	has b	Completed										2433		0	f death?	
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0	dlng th. Afte	흕	1 Neturel 2 □ Accident	5 Pending investigation		ıy Year)	lnj	jury M		rk? ∣Yes 2∐	No					
Division of Vital	i or Attending Physicien: The laveler death. Director: After this certificate has a in by the funeral director, page 2	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Piece of In			m, street, fac	tory, office			28f. Location (m <i>ber</i> or Rui	re/ Route .	Num <i>ber</i> ,
	s effe of in	Sert	4 - Honnicide		building, e	с. (эрөсп	y)					City or To	WII, SIAIO)			
		Medical	29a. Certifier (Check only one)	1☑ Certifying Ph 2☐ Medicat Exam	ysician: To the best niner: On the basis o and menner et	f exempla	wledge, ition end	death occurr or investigati	ed at the tir ion, in my o	me, date en opinion, dea	d plece, th occurr	end due to the ed at the time,	cause(s) and date and plac	manner es e, and due	stated. to the cau	ise(s)
	o the	Z E	29b. Signature end	title of certifier					29c. Licens	se number			29d. Date sig	ned (Month	Day, Ye	ar)
1	H S H Ö		1/1.		1/1/10	K	112		D041	.79			August	4, 2	004	
	4	-	30. Name and addre	ess of person with	completed cause of c	deeth (Iten	n 23e) (T	vpe, Print)			<u> </u>		0			
			James		er, M.D.				Ave.	Chevy	7 Cha	ase, MD	20815			
	Stat Registra		31. Dete filed (Mont	h, Day, Year)	32. Regist	er's Signe	eture	de	racks							

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** Laura Jeannette Meyers August 1, 3:52 рм /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hillhaven Nursing Center, Inc. Adelphi 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Apr. 5, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Davs Hours 1 ☐ M 2 🕱 F 1905 577-03-5324 Washington, DC 99 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rel', or items 23a or 28a-f show Examiner must be notified at 1√ Yes 2 No Takoma Park Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20912 USA 7410 Maple Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3√ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Adjustment 12 Co-President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Laura J. Clement John F. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10120 Towhee Avenue, Adelphi, MD 20783 Judy Fuchs/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August injury or 1 → Burial 2 Cremation 3 Removal from State D Gate of Heaven * 4 ☐Donation 5 ☐ Other (Specify) 2004 Silver Spring, Maryland Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Years Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hypertension Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physiclan/Medlcal as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) □Yes 2 □ No the detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 🕱 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Tes 2**√** No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 5 Pending investigation 1X Natural 1 □ Yes 2 □ No death. 2 Accident after death Director: filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check one) 29d. Date signed (Month, Day, Year) nd title of certifier 29c. License number 29b. Signa August 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

M.d.

32. Begistrar's Signature

Pamela M. Mulshine,

AUG 04

31. Date filed (Month, Day, Year)

10801 Lockwood Drive, #205, Silver Spring, MD 20901

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F		•	giene	n L	251.65
	Physici		Decedent's Name (First, Middle, Last M	o Marlene MU	GMON			2. Date of De Month August	ath Day	Year	3. Time of Death 7:00 P M
	/Medic Examir		4a. Facility Name (If not institution, give Holy Cross Hospit	_		4b. City, Town, o Silver	Location of Death		4c. Count		
	Funeral Director		5. Social Security Number 6. Se 578–54–1667 Usual Residence of Decedent	x	e (In yrs. last birthday) 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug. 16	y, Year)	Cour	place (State or Foreign ofty) ington, DC
	h the Maryland r 28a-f show notified at	tor	10a. State 10b. County Maryland Montgome	erv	10c. City, Town or Lo	er Spring	3			1	0d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number 1709 Billman Lane			10f. Zip Code	902		10g. Citizen of United		
	after or Ite	by	11. Marital Status 1 Never Married AN Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 7 If Yes, Give Year or Dates:	10	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Sin, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, y: wh	
121	e filed within 72 hours al Hygiene. I other than "natural", went, the Madical Exa	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most of wor d)	king	16b. Kind of B		dustry
yland	2 should be filed n and Mental Hygin Is marked other raumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Abraham Gr	ritz			18. Mother's Nam L111	ne (First, Middle, y Hein	Maiden Suman	ne)	
Baltimore, Mar	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other traumatic		19a. Informant's Name/Relationship (T) Malcolm Mugmon, F 20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □ F 1 □ Conation 5 □ Other (Specify) 21. Signature of Furgary Sarvice Licenses	Husband Removal from State	20b. Place of Dispo cemetery, crer Mt . Leban	natory or other plac	ery 08/0	ver Spr	ing, MD 20c. Location Adelph	209 City or To	02 wn, State
	ate be executed / Medical / Medical Examiner fransit the privial-transit	dicai Examiner	23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. List of underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Intrac Due to (or as a	the death. Do not entire. erebral He a consequence of): a consequence of):		St. NW g, such as tardiac	J. Washir of respiratory and	ngton,		On 2 proximate Interval Between Onset and Death 24 hours
Box 6	death certif e attending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	e of deliver	ry Day Year
Δ.	w requires that the s been signed by the should be detache	ed by Pr	Part II. Other significant conditions col				on in Part I.	23e. Did to			e cause of death?
l Rec	The law ate has b page 2 st	Completed by	Respiratory Failu	re, Anemi	a			24a. Was a autops perform	med?	Were autoportor to correleath?	osy findings available apletion of cause of
Division	To the Hospital or Attending Physician: The Is within 2 Hours after death. To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Ospital: Inpatier 28a. Date of Injun (Month, Day) 28e. Place of Injun building, etc	y 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	4 Nursing Ho		ence 6 Otho	er <i>(Specify)</i> ed)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the the	Medical C	29a. Certifier (Check only one) (Check only one)	sician: To the best of ner: On the basis of and manner stat	f my knowledge, death examination and/or invited.	occurred at the tim estigation, in my op	e, date and place, inion, death occur	and due to the cred at the time, d	ause(s) and ma ate and place, a	nner as sta	ited. the cause(s)
	Vithin Vithin Comple	Me	29b. Signature and title of certifier The distribution of the certifier o	Da. M	. 9		number 1003792		9d. Date signed		
	Sta Registr		Irnest S. Oser, M. 31. Date filed (Month, Day, Year)	i.D., 1030			4, Silve	r Spring	, MD 2	0902	

			1 - For State Registrar		yland / Dep	artment of Health a rtificate of Death	and Mental Hyg		251.66
	Physic /Medi		1. Decedent's Name (First, Middle, Last, Helen	J.		yers	2. Date of Dea Month August 1	th	3. Time of Death 11:35 A M
	Exami	ner	4a. Fecility Name (If not institution, give Larkin Chase Nur	sing Home		4b. City, Town, or Location o		4c. County of Dec	Georges
	Funeral Director		5. Social Security Number 6. Set 462-02-1297		(In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 2 Months Days Hours			rthplace (State or Foreign ountry) New York
	within 72 hours after death with the Maryland ene. Itan "natural", or iteme 23e or 28a-f show na Madical Examinat must be notified at	Director	10a. State 10b. County Maryland Prince G 10e. Street and Number	1	Oc. City, Town or Lo				10d. Inside City Limits 1 Tyes 2 No
	23a or	al Dir	15005 Health Cente	r Drive		10f. Zip Code 20715		Og. Citizen of What C United St a	·
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. And I will have a second to the than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinational be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☒ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	ithin 72 ho ne. nen "natur Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	16b. Kind of Business	
d 2	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)		C1	erk	's Name (First, Middle, M	Bookkeepi	ng
ylan	Mental Mental arked atic ev	To Be		Jaffe	,		Rose	(Unkno	wn)
e, Mar	and 2 sho lealth and m 27 is m her traum		19a. Informant's Name/Relationship (Ty, H. Michael Tuckman	, Son	214 W	ng Address <i>(Street and Number</i> hitcliff Court	, Gaithersb		Zip Code) 0878
TOT	ages 1 ent of H nt: # its y or ot		20a. Method of Disposition 1 MBurial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)			natory or other place) non Cemetery 8		20c. Location - City or	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service License	124	22 E	Name and Address of Facility	neral Direc	Adelphi, M	
i.	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.	e dead. Do not ent		ardiac or respiratory arre	VIIIe, MD	Approximate Interval Between Onset and Death MONTHS
760,	eath certificate be executed by attending physician and for use as the burial-transit of	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	DEMENTIA	• ALZHEIM onsequence of):	ER'S TYPE			YEARS
O. Box 6	ine iaw requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
rds, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions con	tributing to death but n	not resulting in the ur	oderlying cause given in Part I.		acco use contribute to	v
		Completed					24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	this certificate al director, pag	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 📉 No	ospital:	2 ER/Outpatien	A.I	f Death <i>(Check only one</i> ing Home 5 ☐ Resider		
Division of	After funer	ation: T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how		ary)
DIVIS	rs after death al Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, stre Specify)	et, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ra i Route Number,
	within 24 hours after or to the Funeral Directory of the Funeral Directory of the funeral Directory of the funeral or to	Medical	29a. Certifier (Check only one) 1 ★ Certifying Phys. 2 ★ Medicel Examin	ician: To the best of mer: On the basis of exand manner stated	amination and/or inv	occurred at the time, date and estigation, in my opinion, death	place, and due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
•	within 24 ho To the Func	Me	29b. Signature and title of certifier	1		29c. License number		d. Date signed (Month	
	T		30. Name and address of person who cor	mpleted cause of death	n (Item 23a) (Type. F	D32261		AUGUST 3,	2004
il.			RICHARD J. FELDMAN	, M.D., 950	OO ANNAPO	*	E A-4 LANHA	M, MD 20	706
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 5 200	32. Registrar's	signature 9	Sporker			

DHMH 17 Rev 1/2001

Physicia	an	1. Decedent's Name (First, Middle, Last) DORIS LOUISE MYEI	RS				2. Date of D	_	Year 2:00 AM M
/Medic Examin		4a. Facility Name (If not institution, give stree CARROLL LUTHERAN VII	et and number)	HCARE		or Location of Deat		4c. County o	of Death
Funeral Director		2.3 .1 300.	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days		B. Date of B	BER 4,192	9. Birthplace (State or Foreign Country) PENNSYLVANIA
death with the Maryland ims 23s or 28e-f show I must be rediffed at	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND CARROLL		City, Town or Li					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
a or 28	Director	10e. Street and Number 1502 PILGRIM LANE			10f. Zip Code	048		10g. Citizen of W UNITED	
or its	by Funeral	11. Marital Status 12. 1 □ Never Married 2 □ Married	Was Decedent Ever in Armed Forces? 1 □ Yes 2 XXVo If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)		- American Indian, , White, etc. WHITE
iene. r than "natural", ine Medical Exe	Completed	15. Decedent's Educati (Specify only highest grade co	on ompleted) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire CLERK	pation during most of wo d)	rking	16b. Kind of Bus	siness/Industry SOCIETY
marked other than	To Be C	17. Father's Name (First, Middle, Last) LEE MILFORD BAILEY				EDITH	MILTII	DA TRUSS	LER
7 is trau		19a. Informant's Name/Relationship (Type, BRENDA S. COX/DAUGH.				tand Number or Ru LANE, FII		per, City or Town, S MD 210	
Importent: If item 27 any injury or other tra	İ	20a. Method of Disposition 1 → Serial 2	20b.	cemetery, cre-	osition (Name of matory or other pla IN MEMORI		8/2004 NS 4/28/		City or Town, State SBURG, MD
Departm Importe any inju		21. Signature of Funeral Service Licensee	aherty,	Lyce	1 WILLIS	STREET.	WESTMI	ME, P.A. INSTER, M	D 21157
hysician /Medical	Ä	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate cause (Final disease or condition resulting in death)	ause on each line.	etren	ter the mode of dy	ng, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
ysicien and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conse	equence of):	Piln	vyiz.	diano	el	200
the attending pathed for use as	by Physician/Med	in the past 12 months?	If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnanc Other (specify)	у		23d. Date Mont	of delivery th Day Year
igned be de		Part II. Other significant conditions contrib	outing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.		200	bute to the cause of death? 3 Probably 4 Unknown
certificate has been s rector, page 2 should	Completed						24a. Was auto perf 1 ☐ Yes	ppsy pri ormed? de	ere autopsy findings available ior to completion of cause of sath? Yes 2 \[\sum \text{No} \]
rilysicien: The this certificate hi ral director, page	o Be (25. Was case referred to medical examiner?	oital: 1 ☐ Inpatient 2	☐ ER/Outpatie		han Till	ath (Check only		
	-	27. Manner of Death 1/ Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju Wo			idence 6 Other how injury occurred	
th. : After this s funeral di	Ě			h	roat factory office		28f. Location		r or Rural Route Number,
s after death. I Director: After this Id in by the funeral di	Sertification	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, rarm, st	eet, factory, office		City or To	own, State)	
nours after death. nerel Director: After filled in by the funer	edical Certification;	datarminad	building, etc. (Specars)	owledge seat	h occurred at the ti	me, date and place opinion, death occu	City or To	cause(s) and man	ner as stated. nd due to the cause(s)
After funer	Medical Certificati	4 Homicide determined 29a. Certifier (Check only 2 Medical Examine)	an: To the best of my k	owledge seat	h occurred at the ti vestigation, in my o	opinion, death occu	City or To	cause(s) and man date and place, an	ner as stated. nd due to the cause(s) (Month, Day, Year)

			1 - For State Registrar	State of Ma				lealth and Death			Rag. No	1000	251	168	
	Physici /Medic		1. Decedent's Name (First, Middle, La Janice Ela	ine Norton						Date of De Month	Da	y Year 2004	3. Time 2:00	of Death	
	Examir		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death					4c. County of Death			
	Funeral Director		Manor Care - Potomac				Potomac					Montgomery			
ľ			5. Social Security Number 6. Sex 1 M 2 XF 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept. 30, 1918 Wash								rthplace (State Sountry) hingtor				
	ryland thow	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	ocation			<u>.</u>				10d. Inside	City Limits	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or Iteme 23a or 28a-f show any injury or other treumatic svent, the Medical Evant as mitted any one.	cto	MD Montgom	ery	Potomac									es 2X No	
		Dir	10e. Street and Number 10714 Potomac Ten	nis Lane			Zip Code 20854	•			-	itizen of What C	ountry?		
Baltimore, Maryland 21215-0036		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates:	ver in U.S. 13	in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					0-	14. Race - American Indian, Black, White, etc. Specify: White			
		Completed t	15. Decedent's Education 16a, Decedent's Usua					f work done during most of working					s/Industry		
		Com	4 Actress									ntertair	nment		
		To Be (17. Father's Name (First, Middle, Last) Albert G. Norton				18. Mother's Name (First, Middle, Maiden Sumame) Dorothy Wood								
			19a. Informant's Name/Relationship Mimi Norton Salam	• •				and Number or Drive I				or Town, State, .0854	Zip Code)		
			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 L 4 ☐ Donation 5 ☐ Other (Speci		20b. Place of Disposementery, critical Cedar H:	ematory o	r other plac	Aug	Date Sust 20(ocation - City or			
Balt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility 33. Name and Address of Facility 34. Name and Address of Facility 34. Name and Address of Facility 35. Name and Address of Facility 36. Name and Address of Facilit												
1	Pnysician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Abdominal Malignancy Due to (or as a consequence of):											Approxim Interval B Onset an	Between	
of Vital Records, P.O. Box 68760,	The law requires that the death certificate be executed atte has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Ilcal Examiner	fi any, leading to immediate cause. Enter Underlying Cause. [Decease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):												
		Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【XNo 9 ☐ Unknown	ast 12 months? 4 Pregnant at time of death 5 Other (specify)						23d. Date of Month			olivery Day	Year	
		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give									acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 □∭Unknown			
		Completed								24a. Was auto perfo 1 Yes		prior to death?	utopsy finding completion of	s available cause of	
	ysicien: 1 is certifical director, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one) Hospital: Other: You and Table 1975 A Control of the Contro											
	00 CO TT	-T	1 Yes 2 XNo 27. Manner of Death	1 Inpatient 2 EH/Outpatient 3 DOA 4 ANNUrsi						g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
DIVISION	tending leath. tor: After the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury Work? Injury Work? Injury Work? Injury Work?											
2	of the Sir		4 Homicide determined	(Specify)					City or Town, State)						
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier 1 (\(\tilde{\infty}\) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) (Check only one) (2 \(\tilde{\infty}\) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
2		Me	29b. Signature and title of certifier				29c. License number D0054566				29d. Date signed (Month, Day, Year) August 2, 2004				
•	3		30. Name and 21 ss of person who Sunitha Bhogavill				East	Joppa	Road	l Tow	son,	MD 212	86		
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar		Sou	uh	,							

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		19.	1. Decedent's Name (First, Middle, La	10a,e per	th g	3 <u>840~2+</u>	<i>г</i> ущ у ус	Af Dec	21/1	2. Date of D	eatn		3. Time bf	Death
	Physicia /Medic		WILLIAM L	AYTON NI	BLET	ГТ				JUNE	24, 200		0806	A^{M}
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430	Funeral Director	3	5. Social Security Number 6.		e (In yrs. i	last birthday) Yrs.	If Under 1	Year If U	Inder 24 Hrs. ours Min.	8. Date of B	irth Pay, Year)		lace (State or	r Foreign
Duelvie	show and all	J.	Usual Residence of Decedent 10a. StateMD. 10b. County Wicomi	CO		y, Town or Lo	cation			•		1	0d. Inside Cit	
£ M	28a-f	Director	10e. Street and Number			- Initial	10f. Zip (Code			10g. Citizen of	What Cour	itry?	
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5-00	"natural"	ompleted t	15. Decedent's E (Specify only highest gi	Education		(Give	ent's Usual kind of work OO NOT use	Occupation done during	nost of wor	rking	16b. Kind of E	Business/Inc	dustry	
127	than	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	Car S					Car D	ealer		
Maryland 21215-0036	e de la la la la la la la la la la la la la	Fo Be C	17. Father's Name (First, Middle, Las William Henry							ne (First, Middl / Futch	e, Maiden Sumal er	me)		
Mary	5 th 25 th		19a. Informant's Name/Relationship Carolyn Wisniew			19b. Mailin	g Address 7 Sus	Street and H	Tghwa lay , D	ral Route Num elmar,	ber, City or Town DE 1994	, State, Zip 0	Code)	
Baltimore,			20a. Method of Disposition 1 Surial 2 □ Cremation 3		, c	lace of Dispo	natory or oth	her place)		Date	20c. Location	•		
time	Department of Important: If any injury or once.		`4 ☐ Donation 5 ☐ Other (Spec	ify)	Nev	w Hope		etery Address of I	1	9-04	Willard			
Bal	Departr Departr Importa any inju		21. Signature of Funeral Service Lice	enter _	_					ral Hom	10		n St., d. 218	!!
	nysician /Medical Examiner	er	23a. Part1. Entering disease, or cor shock, or head railure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	clero	otic Countries		III Cal.	шу ну	pertens	sive		Approximate Interval Bety Onset and D	veen
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×	inal the death cern ed by the attending detached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pre Other <i>(spe</i>					ate of delive onth	-	'ear
	quires mat in signed b uld be deta	by	Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying ca	use given in	Part I.		tobacco use cor]Yes 2□No	itribute to th 3 ☐ Prob	1.7	eath? Inknown
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Divis	To the Hospital of Attending Prysician: The lay within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				eet, factory,	office		28f. Location City or T 346 Wor	(Street and Num own, State) ROC cester (ite ⁸ 50 County) Rote Rote 7, MD	ite
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	vithir To th comp	Me	29b. Signature and title of certifier	11.16.	/		29c.	O.C.N			29d. Date signe JUNE		Day, Year) 2004	
,			30. Name and address of person wh	o completed cause		n 23a) (Type, L1 Penr		et. R	altimo	re. Mar	yland 21	201		
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	Regist		JUN 2 8	2004 Steel	m.	& A	soli)							

State of Maryland / Department of Health and Mental Hygiene State
Registra/AMFND#5perINF8/2/04, EMW, McCo Certificate of Death Reg. No) 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 27, July 2004 2:16 Mary Leonard Naiman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 10409 Amherst Avenue Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 64 8. Date of Birth (Month, Day, Y Apr. 20, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🕱 F Maine 75 Ĩ929 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show r then "neturel", or items 23e or 28e-f shov the Medical Examiner must be notified at 1 Yes 2 No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20902 10409 Amherst Avenue USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) fited within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home is 1 and 2 should be filed virt Health and Mental Hygie Item 27 is marked other t other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David Leonard Ella Crandall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marc L. Naiman, Sr./ 3 Chester Circle, Glen Burnie, MD 21060-7350 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot August 2 cometery camaton of other place) Mary I and Veteran's ortent: If I 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Cheltenham, Maryland cemetery 21. Signature of Funeral Service Licensee/ 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ischemic Heart Disease 10 Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transli certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai as the t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Hypertension Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 2 X No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 2 🔀 No 1 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? B Hospitel or Attending Pl 24 hours after death. 9 Funerel Director: After the 1 🛎 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medicel Examiner: On the basis of examination and/or investigation, and manner stated. in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 D20674 July 28, 2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Stephen Hellman, M.D. 6240 Montrose Road, Rockville, MD 20854 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 JUL 29 Registrar

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Domin Idean T Ordonaz	3
Romualdson T. Ordonez	State of Maryland / Department of Health and Mental Hygiene

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		1	Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of	Death
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7	Examin		4a. Facility Name (If not institution, give street and nu		4	4b. City, Town, or	Location of Death		4c. County			
			Prince Georges Hospita				erly If Under 24 Hrs.				eorges	
п	Funeral		5. Social Security Number 215.69.0455 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last b		If Under 1 Year Months Days	Hours Min.	8. Date of Bird (Month, Da	n y, _{Year)} 25 , 1977	9. Birthp Coun	lace (State or	Foreign
Н	Director		Usual Residence of Decedent					March	23,19//	LIIII	трртпе	<u>s</u>
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	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 le marked other than "natural", or Items 23e or 28e-f show other treumetic event, the Madical Expiriting formal be indifficed at	Funeral Director	6812 Landon Court 11. Marital Status 12. Was Dec	edent Ever in U.S.	13. Wa			ecify Yes or No		e - Americ		
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215-0036	al', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Gi	re ates:	1L	Yes 21☑No	Specify:		Specify	y: Asia	an	
5-0	natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16	(Give kit	nt's Usual Occup	during most of work	ing	16b. Kind of B	usiness/Ind	dustry	
121	within ene. than "	mpi	Elementary/Secondary (0-12) College (2 Yea	1-4or 5+)		NOT use retired al Thera	" apist Aide	2	Health	care	Sorvi	COC
d 21	filed withi Hygiene. other ther		17. Father's Name (First, Middle, Last)	115 1			18. Mother's Name				DELVI	
an	nould be to Mental I marked o netic eve	To Be	Romualdo Ordonez				Asuncion	Trivi	no			
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	and 2 valth a n 27 le		Maximynn Perez Carino/Co				ourt, Gre					J.S.A.
Baltimore,	of He of He If iten		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑ Removal from	State Ever	of Disposit	ion (Name of tory or other place	rial 08/21	Date / 200/	20c. Location - Susana	Heigh	nt.	
Ë	tent:		* 4 ☐ Donation 5 ☐ Other (Specify)	DVELE		Park	1	1	Muntinl	upa,	Philip	pines
Bal	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Ite		21. Signature of Funeral Service Licenses Nancy A. Vercan	tie	HÎN 118	NES-RINA 800 New	ss of Facility LDI FUNER Hampshire	AL HOME Ave, S	, INC. ilver S	pring	g, MD 2	20904
Г			23a. Part1. Enter the discase, or complications that of shock, or heart failure. List only one cause on a	aused the death. Do	o not enter	the mode of dyin	g, such as cardiac	or respiratory a	rest,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	ul and	Nu	h mi	hrles					
	/Medical Examiner		Due to	(or as a consequenc	ce of);	' 0						
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the base of the base of the control on the									1 244
	o the ithin o the omple	Me	29b. Signature and title of certifier	1101 0101001		29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)	
	FSFO		IThe ulli	6		OCME			August	5, 20	004	
	>		30. Name and address of person who completed cau	of death (Item 23a	a) (Type, Pr	int)				·	. 3 011	201
			THEODORE M. King			111 Pe	enn Street	t, Balt:	more, M	aryla	and 212	201
	Sta		31. Date filed (Month, Day, Year) 34. F	Registrar's Signature	A	Spark	()					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death ime of Death 1. Decedent's Name (First, Middle, Last) . 2004 July 31, 7:40P M William Bernard Outlaw 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Casey House Montgomery Hospice Rockville Montgomery If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Oct. 24, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 241-80-0365 Ĩ949 54 Washington, NC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring Montgomery XXYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 306 South Waterford Road 20901 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry American Diabetes Elementary/Secondary (0-12) College (1-4or 5+) 5+ Director of Publication Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernard Outlaw Cleo Pugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Veronica Oliver - Sister 12 Kinsey Way, New Castle, DE 19720 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Out law Family August 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 Windsor, North Carolina ³ 4 □ Donation 5 □ Other (Specify) Cemetery 22. Name and Address of Facility CGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medica Examine

Physician

/Medical

Examiner

Completed by Funeral Director

Be

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10a, State MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28a-f show any injury or other treumatic event, the Medical Examination at once.

Baltimore, Maryland 21215-0036

burial-transit

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed filled in by the funeral after death. within 24 hours a To the Funerel C npletely

Division of Vital Records, P.O. Box 68760,

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Immediate Cause (Final disease or condition	Liver Ci	rrhosis				Years
resulting in death)	Due to (or as a consec	quence of):			-	
O THE PLAN OF THE PARTY OF THE	, Hepatiti	s B				Years
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resulting in death) Last	Due to (or as a consec	ruence of);				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of o	il death 3 ☐Ectopic			23d. Date of de Month	livery Day Year
Part II. Other significant condition	ns contributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco 1 ☐ Yes		the cause of death?
				24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical			26. Place of De	eath (Check only one)		
examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	OOA Other: 4 Nursing	Home 5 ☐ Residence	6 X Other (Spe	_{cify)} Hospice
27. Manner of Death XXNatural 5 Pending 2 Accident investig	ation	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how inj	ury occurred	
3 Suicide 6 Could no determine		ome, farm, street, factory)	ory, office	28f. Location (Street a City or Town, Sta		ural Route Number,
29a. Certifier 1 Certifying (Check only one)	g Physician: To the best of my kno examiner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	ce, and due to the cause(curred at the time, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
29b. Signature and title of certifier		2	9c. License number	29d. D	ate signed (Mont	h, Day, Year)

D35635

racks

August 01, 2004

6001 Muncaster Mill Rd., Rockville, MD

20855

State

Registrar

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Joseph Kaplan, M.D. 6001 Muncaster Mill,

2004

31. Date filed (Month, Day, Year)

AUG 04

State Registrar

31. Date filed (Month, Day, Year)

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Panela E. Southall,

AUG 0 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

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AUGUST 2, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 2004 **Physician** A^{M} JULY 29, 7:15 PEARL POLLACK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY 1801 EAST JEFFERSON STREET #206 ROCKVILLE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Months 1 ☐ M 2 🛛 F NEW YORK 03/04/1910 Director 94 058-28-7217 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location 10a. State in than "natural, or items 23s or 28e-f show the Medical Examinat must be notified at 1 Yes 2 No Funeral Director MARYLAND MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1801 EAST JEFFERSON STREET #206 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite may injury to pthar treumatic avent, the Medical Exerciting any injury. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify. þ WHITE 3 ∑Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) NEW YORK Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS GUIDANCE COUNSELOR 5-⊦ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DORA COOPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4821 MONTGOMERY LANE, BETHESDA, MARYLAND 20814 MARY ANN POLLACK DUBNER/DTR. Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/01/2004 ELMONT, NY BETH DAVID CEMETERY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (briss a soneaguence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of) Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by been signe should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2X No the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 😾 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending To the Hospins...
within 24 hours after death.
To the Funeral Director: Aft 1 Yes 2 🗆 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified JULY 30, 2004 D36797 30. Name and address of person who completed cause of dean (Item 23a) (Type, Print) 10215 FERNWOOD RD., BETHESDA, MD 20817 ALAN SHEFF, M.D.,

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

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100 send

32. Registrar's Signature

			For State Registrar	State of M	laryland /		rtment of F		and Mo	ental H	ygier Reg. I	000	1	251	75
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	/Medic Examin		4a. Facility Name (If not institution, give s)		4b. City, Town, o	r Location o				4c. County of	Death	1 0 1 2 0	
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9	or It	/Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give			Yes 25√2 No	Specify:				Specify:	Whi	te	
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and and	be fi	Be	Robert J. Cross							M. Po					
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	To Too	Σ	29b. Signature and title of certifier				29c. Licens	5880							
	01		Lenny	-9			D4:					August	۷,	2004	
	1-		30. Name and address of person who co	1											
			Leon Hwang, M.D.				Drive, I	Rockvi	lle,	MD 20	0850				
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	•	For State Registrar	State of Ma	aryland		irtment of l tificate of			giene Rog. No	63 63 63 1	251.76
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/Medic	al -	Doris We	ebb Pryo	r		4b. City, Town,	or Location of De			County of Deat	
Examini	21 **	Potomac Valley N		9		Rock	ville			Montg	gomery
Funeral Director		5. Social Security Number 6. S 577-03-7798	I M OFKE	98	st birthday) Yrs.	If Under 1 Year Months Days		lin. 8. Date of Bir (Month, Da	th iy, Year 19	9. Birtl Co Mi. s	nplace (State or Foreign untry) SSOURI
P .		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation					10d. Inside City Limits
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should Me mark	ဥ	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Stree	t and Number of	Rural Route Numb	er, City	or Town, State, 2	(ip Code)
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		30. Name and address of person who Anurita Mendhi					1 v.d #	330. Rocks	vi 11	e. Md. 2	20850
₹ Sto	to	Anurita Mendri 31. Date filed (Month, Day, Year)	32. Registra					Joo, ROCK		.c, ma 2	
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	Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom	ıery	10c. City, T		sburg							side City Limits ☐ Yes 2 No
	h with the 23a or 28 st be not	ai Director	10e. Street and Number 8334 Tea Rose Dri	.ve			10f. Zip 20	Code 8 7 9				10g. Citizen of W USA	/hat Country?	
980	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or tems 23a or 28a-1 show soonly. I've Medical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	- 1	Was Deced If Yes, spec 1 X Yes 2				ecify Yes or No Rican, etc.)		e - American Ind k, White, etc. - White	Jian,
21215-0036	d within 72 hogiene. ar than "natu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or		(Give life.	dent's Usua kind of wor DO NOT us emake	k done d e retired,	ation Juring mos)	t of worki	ng	16b. Kind of Bu	siness/Industry	
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	ss 1 and of Health item 27		19a. Informant's Name/Relationship (T) Maria Baeza/ Daug 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	hter	20b. Place	833 e of Dispo	4 Tea	Ros	e Dri	ive,		rsburg, 20c. Location - 6	MD 2087	9
Baltimore,	permit. Pages 1 Depertment of + Important: If ite any injury or ot		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens)	00	Cı 22 F		ory d Addres s J.	Coll	20 Lins	04 Funera	Alexandr	nc.	
}	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. QCU	ine.		er the mode	e of dying	g, such as	cardiac c	Sance	rrest,	Appro Interv Onse	MD 20901 eximate val Between et and Death
,092	Examiner sician and shrial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. 144 C Due to (dr as		ce of):	۰۰۸						4.	eurs
.O. Box 68	death certific e attending pl id for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3	Ectopic pro					23d. Date Mon	of delivery th Day	Year
۵.	luires that the signed by ald be detacted	by	Part II. Other significant conditions co	ntributing to death t	but not resultin	g in the u	nderlying ca	ause give	n in Part I.			obacco use contri res 2 □ No		
Il Records,	The law requires that the sate has been signed by the page 2 should be detache	Completed									24a. Was autop perfor 1 Yes	rmed? pr	/ere autopsy finition to completion aath? ☐ Yes 2 ☐ ₩	
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	April 1		(Check only o			
of	ding Phys	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		Outpatier b. Time of Injury		Bc. Injury Work	4 🗀 Nu	2		dence 6 Othe		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	200. Place of III	jury - At home tc. (Specify)	, farm, str	eet, factory	, office			28f. Location (S City or Tow	Street and Numbe vn, State)	r or Rural Route	e Number,
	the Hospi nin 24 hou the Funer pletely fill	edical	29a. Certifier 1 Certifying Phy (Check only one) 4 Medical Exami	rsician: To the best iner: On the basis of and manner st	of examination	dge, death and/or in	vestigation,	in my op	inion, dea	d place, a th occurre	ed at the time,	date and place, a	nd due to the ca	
•	To with	Σ	29b. Signature and title of certifier	Sheri	ill 1	$n \cap$		License	G	9	C	29d. Date signed	at4 12	ear)
	1		30. Name and address of person who co Deborah J. Sherr			а) (Туре,	Print) Med	رما	Cent	er D	r. Roci	kville, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 5 200	32. Pregisti	rar's Signature			rks						

		•	For State Registrar	State of Marylan		rtment of H			ene 2. No. 2004	25478
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last	THER RO	OKCH			2. Date of Death Month Tuly	Day Year 21 2004	3. Time of Death 4:30P M
6	Examin	75.	4a. Facility Name (If not institution, give 800 Hotter		109	4b. City, Town, or Freder	ick	,	4c. County of Death Frederic	
	Funeral Director		201-03-3606 /	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	9. Birthp Cour 1918 South	lace (State or Foreign http) 11 AMCTICA
	Maryland		Usual Residence of Decedent 10a. State 10b. County Md. Fredey		ty, Town or Lo				1	0d. Inside City Limits
	a or 280-	Funeral Director	10e. Street and Number 800 Mottler	Ave Apt	409	10f. Zip Code	101	10	g. Citizen of What Cour	itry?
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f ehow mportant: If item 27 is marked other then "natural", or items 23a or 28e-f ehow hy highly or other traumatic event, the Medical Examinating mea	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	J.S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto in Specify:	city Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B14	etc.
21215-0036	I within 72 hou jiene. r then "nature the Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Deced (Give life. L		ition luring most of workii)	ng A	sb. Kind of Business/In a. State Lig Control Bo	9400
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last)	ier Roach			18. Mother's Name Kqfh/CC		aiden Sumame) Ludecker	
	and 2 shou alth and h		19a. Informant's Name/Relationship (T. RICAY do ROAC)	he (son)	9709	Spence	r Lane.	Acceptable .	City or Town, State, Zip	21754
Baltimore,	Peges 1 and of He		20a. Method of Disposition 1 Burial 2 Cremation 3 . 4 Donation 5 Other (Specify	Removal from State	Place of Dispo cemetery, crem : Hhsbur	sition (Name of natory or other place	tony July 2		oc. Location - City or To	
Balti	permit. Pege Department o Important: If eny Injury or		21. Signature of Funeral Service Licenty		110	Name and Address	is it acilities then touth St	Frederice	e h md. 217	01
	Physician		23a. Part1. Enter the disease, or comp shock, or hear failure. List only of Immediate Cause (Final disease or condition	plications that caused the deal	0		g, such as cardiac o	-	/~	Approximate Interval Between Onset and Death
# .	/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events	Due to (or as a consect Due to (or as a consect C.	quence of):					
,092	ate be executed hysician and he burial-transit	cal	resulting in death) Last	Due to (or as a consec	quence of):					
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	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying cause give	en in Part I.		acco use contribute to the 2 □ No 3 □ Prot	
I Records,	The law ate has b page 2 s	Completed	10	70	-			24a. Was an autopsy perform 1 \(\text{Yes} \) 2	prior to co death?	psy findings available mpletion of cause of 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	3	Othe	26. Place of Death			president a series
of	ling After Tune	ation: To	27. Manner of Death 1 Description 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at Nursing Ho	me 5 Hesiden 28d. Describe how	ice 6 □Other (Specifi v injury occurred	y)
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	Hospii 24 hour Funer stely fill	edical	29a. Certifier 1 Certifying Phr (Check only one) 2 Medicel Exert	ysicien: To the best of my kn niner: On the basis of examina and manner stated.	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due to	tated. the cause(s)
	To the within To the	Me	29b. Signature and title of certifier	/11/ At	1/10	29c. License	number	290	d. Date signed (Month,	Day, Year)
,	E		30. Napre and address of person who	ompleted cause of death (Ite	gn 23a) (Type,	Print)	55/8	5	Jelly 26,	2004 Linn
	5		31. Date filed (Month, Day, Year)	32. Røgistrar's Sign	30	90 CC	. Joh	STIF	afferic	K MD
	Sta Regist		JUL 2 8 2	004 Seres	19	Loon	Ka).			

			1 - Stata Registrar	State of M	aryland / Depa <i>Cel</i>	artment of H rtificate of L			giene Reg. No 11 11	1 25	7.0
			Decedent's Name (First, Middle, Last))				2. Date of De	ath		o of Death
i d	Physici		James Thomas Ruth	erford.	Sr.			Month August		fear 5:3	4 PM
Sep.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	<u></u>	4c. County of		
	LAdiijii	Ç.	Holy Cross Hospi	tal		Silver	Spring		Monto	jomery	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th Year!	9. Birthplace (Stat Country)	e or Foreign
	Director		579-05-4722]M 2□F	87. Yrs.	Months Days	Hours Min.		28. 1916		
	<u> </u>		Usual Residence of Decedent		140-07-7						
	rylan	_	10a. State 10b. County		10c. City, Town or Lo	cation					City Limits es 2 ₩No
	Ba-1 s	ct	Maryland Montgom	ery	Silver						
	ith 19	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?	
	ath w		1807 Brisbane St		D	20902	Odeina (Con	ait. Van as Na	USA	A American Indian	
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	?	if Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto	Rican, etc.)		White, etc.	,
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	1X Yes 2 ☐ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	White	
21215-0036	72 hours after death with the Maryland Insturat, or Items 23s or 28s-f show disal Evaninat must be notified at	ed	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busi	ness/Industry	
15	in 72 an" n	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired.	turing most of worki	ng			
12	within iene. than "	E O	Elementary/Secondary (0-12)	College (1-4or	Asb	estos Wor	ker		Insula	ıtion	
	Hyg otha	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle	, Maiden Sumame)		
an	Henta Wenta Ked Iic ev	To B	Agustus V. Ruthe	rford			Margar	et Lin	coln		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Itam 27 is marked other than "natural", or Items 23a or 28a-1 show item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic evant. The Medical Examinar must be rediffied at		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	ng Address (Street a	and Number or Rura	I Route Numb	er, City or Town, St	ate, Zip Code)	
	and 2 tealth a im 27 is		James T. Rutherfo	rd, Jr./	Son 180	7 Brisban	e Street	_Silve	r Spring.	MD 2090	12
ore	of He itam		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F	Romoval from State	cemetery, cres	natory or other plac	θ) ham	ate ist 6,	20c. Location	ity or Town, State	
Ĕ	Page Int: If)	1 ♣ Burial 2 ☐ Cremation 3 ☐ Property		Jaco	of Heaven meterv		04	Silver S	bring. N	MD.
Baltimore,	permit. Pages 'Department of Himportent: If its any injury or of once.		21. Signature of Faneral Service Licens	00	22	Name and Addres	ss of Facility Collins	Funora			
B	80 E E 8		1 (inchen	Klok	£ 5	00 Univer	sity Blvd	. W.	Silver Sp	ring, MI	20901
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that cause ne cause on each I	d the death. Do not ent	er the mode of dyin	g, such as cardiac o	r respiratory a	rrest,	Approxin Interval	nate Between
5	Physician		Immediate Cause (Final disease or condition	•	c Arrhythm	ia				Onset ar	id Death
F	/Medical		resulting in death)	v	a consequence of):						
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8760,	physii the t	dicai		d. Corona	ry Artery	Disease			·		
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Вох	death certifi e attending p d for use as	ian	in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Month		Year
o.	the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	it time or death 32						
Δ.	w requires that the death been signed by the atte should be detached for	by Physician/Me	Part II. Other significent conditions co	ntributing to death I	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use contrib	ute to the cause of	of death?
Records,	sign d be		Chronic Obstruct	ive Lung	Disease			1 🗆	Yes 2 x ∑No 3	☐ Probably 4	□Unknown
Ö	v request	ete						24a. Was	an 24b. We	ere autopsy finding	ns available
3e	nysician: The law on secrificate has but director, page 2 sh	Completed						auto	psy prio	or to completion of ath?	cause of
a								1 Yes		Yes 2□No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	4 T F D 10	Othe	26. Place of Death			(0	- 1
٥	E = E	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inju	ient 2 ER/Outpatier ury 28b. Time o	II 3 DOA	4 Li Nursing Ho		dence 6 Other		
on	ding Afte fune	tlon	1 ☑ Natural 5 ☐ Pending	(Month, Da		Worl	k? Yes 2 □ No				
:0	Attanding r death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be	200. Flace of III	ijury - At home, farm, str	reet, factory, office			Street and Number	or Rural Route N	umber,
Division	after Dire	Certification:	4 Homicide	building, e	tc. (Specify)			City or To	wn, State)		
	Hospital		29a. Certifier 1x Certifying Phy	sician: To the best	t of my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the	cause(s) and mann	er as stated.	
	a Hos 24 h a Fur letely	Medical			of examination and/or in						∋(s)
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Month, Day, Year)
			A. Bohn	stone		D4	7928		8/3/0	24	
	8+1		30. Name and address of person who c			Print)		201			20000
_			Lila Mojdeh Bahad	ori, M.D.	. 10301	Georgia A	venue, #3	304, Si	lver Spri	ng, MD 2	10902
*	Sta		31. Date filed (Month, Day, Year) AUG 0 4 20		trar's Signature	Spark					

	1	State Amend Item 23	State of a&pt.I	Maryland I per p l	l/Depa h y C8	rtment of H	ealth and tas	Mental Hyو ا	giene Rog. Nĝ. () ()	05100
		I. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath 2004	-3. Time of Ceath
Physician /Medical		Nabiha Mariam Saa	h					July 2	9, 2004 Ye	12:17 PM
Examiner		a. Facility Name (If not institution, give s		nber)		4b. City, Town, or	Location of Deat	h	4c. County of D	eath
		2324 East Gate D				Silver			Montg	
Funeral Director	5	i. Social Security Number 6. Sex 219-48-5395 1□	M 21/4 F	7. Age (In yrs. Ia 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	7, 1912 9.	Birthplace (State or Foreign Country) Palestine
put 🛊	-	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation				10d. Inside City Limits
haryle r e bo		Maryland Montgo				Spring				1 Tes 2 No
the h	-	10e. Street and Number	шегу		LIVEI	10f. Zip Code			10g. Citizen of What	Country?
3a or		2324 East Gate D	rive			20906	5		USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Itam 27 le marked othar than "natural", or Items 23s or 28s-1 show any injury or othar treumatic event, the Medical Examination in the collision at once. To Be Completed by Funeral Director		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Dece Armed For 1 Tes If Yes, Give Year or Da	2 ∑ No e	1	Was Decedent of Hi f Yes, specify Cuba □ Yes 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	specify Yes or No- to Rican, etc.)		merican Indian, /hite, etc. hite
ed within 72 hour ygiene. Par than "natural to the Madical E. t, the Madical E.		15. Decedent's Educ (Specify only highest grade	ation		(Give	lent's Usual Occupa kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Busine	ess/Industry
ed will right arth		10			Но	memaker			Own Hor	ne
be file d outh	3	 Father's Name (First, Middle, Last) Ayoub Hanna Ayo 	ub					me <i>(First, Middl</i> e, ela Mikh	Maiden Sumame) a i 1	
I Meni		19a. Informant's Name/Relationship (Ty)			40h 84-iii-	- Address (Ctennes			or, City or Town, Stat	a Zia Cada)
d 2 st th and 7 le n treun		Amelia Saah/ Dau							ville, MD	
1 and Healt Iam 2		20a. Method of Disposition	gircer	20b. Pla	ace of Dispo	sition (Name of	1	Date	20c. Location - City	
ages ant of tr: Fil	ì	1 ③XBurial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from S	State Ce	ParkI norial	natory or other plac awn Park		ug. 2, 2004	Poglerri 11.	backward a
permit. F Departme importer any injur		21. Signature of Funeral Service License		Hen	22 F	Name and Address	s of Facility Collin	s Funera	l Home Inc lver Spri	e, Maryland c. ng, MD 20901
hysician /Medical Examiner sthe burial-transit sedical Examiner		shock, of heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence or a consequence or a consequ	ence of):	ic Pulmor	eary Fib	rosis		Onset and Death
requires that the death certific teen signed by the attending phould be detached for use as the by Physician/Mec) Sicial Pier	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bi	come of pregnar irth 2 Fetal ant at time of de own	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
es tt	2	Part II. Other significant co nditions cor - Obstructive Lung			lting in the u	nderlying cause give	en in Part I.		obacco use contribut res 2 No 3	e to the cause of death?] Probably 4 X Unknown
The law ate has by page 2 s	oduible								rmed? prior death	autopsy findings available to completion of cause of n? Yes 2 No
ysician: This certificate director, pag	2	25. Was case referred to medical examiner?	ocnital:			Othe	26	ath (Check only o		
ling Phys	1	27. Manner of Death 1 Anatural 5 Pending			PVOutpatier 28b. Time of Injury	28c. Injun Work	/ at		tence 6 Other (S	Specify)
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:		2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place buildir	of Injury - At hor ng, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (S City or Tox		Rural Route Number,
To the Hospital within 24 hours a To the Funaral I completely filled Medical Ce				asis of examinati					cause(s) and manner date and place, and	
To the comp		29b. Signature and title of certifier	4/1	Ze_		29c. License	-112 1	5	7/30	onth, Day, Year)
	-	30. Name and address of person who co	mpleted caus				1 +0	0	1	, - 1
		Charles Harriso				-		Rockvill	e, MD 208	55
State Registrar	-	31. Date filed (Month, Day, Year) AUG 0 2 200		egistrar's Signat	ure 5	Sporks	/			

			For State Registrar	State of N	/larylan		artment o			and Me		jiene	11.	2510	-1
	Dharaisi		1. Decedent's Name (First, Middle, La		_						. Date of Dea Month	th Day	Year	3. Time of D	-
	Physici: /Medic			ABZVA							746	03 8	2004	2:10	EM.
4	Examin		4a. Facility Name (If not institution, giv			Harp	4b. City, To	_		_	A-	4c. County			
			5. Social Security Number 6. S	Y GENE		last birthday)	If Under 1		ンレロ If Under 2	1 MB1	. Date of Birth		S AR		oreign
н	Funeral Director			□M 2026F	80	Yrs.			Hours	Min.	(Month, Day	, Year)	Ira	lace (State or Fi try)	oreigir
	_		Usual Residence of Decedent							μ1	ug. 14	, 1723	110	.11	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						1	0d. Inside City I	
	e Ma-f s	ctol	Maryland Montgo	mery	Br	ookev	ille							1 ☐ Yes 2k	X _M 0
	iff the	Dire	10e. Street and Number				10f. Zip Co				1	l0g. Citizen of V		try?	
	8 23a	Funeral Director	2709 Goldmine Roa		t Fuer in II	C 112		0833	io Orio	in? /Consi	ty Voc er No	Ir	an e - Americ	an Indian	
	er de	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 Yes 2	s?	.5. 13.	Was Deceden If Yes, specify	Cuban,	Mexican.	, Puerto Ri	can, etc.)		k, White,		
36	irs aft	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2√	₹No	Specify:			Specify	· Wh:	ite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modical Exemirer must be notified at	ted	15. Decedent's E			16a. Dece	dent's Usual C	Occupati	ion	at warding		16b. Kind of Bu	siness/Inc	lustry	
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	/Medical		disease or condition resulting in death)	a. Due to (or a	as conseq	uence of):	COL							day	1
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x 68	leath certifical attending phy d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancy						1024 Day	o of dolino		
Вох	atten atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Feta	Ideath 3	Ectopic preg					Mor	e of delive nth	ry Day Yea	ır
o.	that the de led by the a detached i	ysic	1 ☐ Yes 2 █No 9 ☐ Unknown	9□ Unknown		0411	2 0 11101 (0,000)	,,							
Δ.	that led by deta	4	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying cau:	se given	in Part I.		23e. Did to	bacco use contr	ibute to th	e cause of deat	th?
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Vital		a	. Was case referred to medical	1	per	100			26. Place	of Death (Check only or	7			
*	Ø 2. ₹	To B	v examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpa	atient 2 🗆	ER/Outpatier	nt 3 DOA	Other	: 4 ☐ Nui	rsing Home	5 ☐ Resid	ence 6 □Oth	er (Specify)	
n of	ding Pt After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time o Injury	f 28c	. Injury a Work?	at	28	d. Describe h	ow injury occurr	ed		
Si	endin eath. or: A	catio	2 Accident investigation				М	-5	es 2 □ N						
Division	or Att	Certification:	4 Homicide determined	280. Place of	Injury - At he etc. <i>(Specif</i>	ome, farm, sti by)	reet, factory, o	office		28	f. Location (S City or Town	treet and Numben, State)	er or Rura	l Route Number	,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai		miner: On the basis and manner	of examina										
	o the	Med	29b. Signatura and title of certifier				29c. L	icense	number		2	9d. Date signed	(Month,	Day, Year)	
	- 3 - 0) (Mo , m)	FCCP			0	34	845)		Alia	12	200	24
	\mathcal{V}		30. Name and addless of person who	completed cause of	of death (Iter	n 23a) (Type,	Print) M A	71-	CHI	NA	UYEN	1 100) 1	CCP	7
			7350 grace	- thire	, Col	und	aa	H	0	210	44) (~)	, (,	
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	Regist	rar	AUG U 4 20	JU4 /2	eva	19	Space	Kal	/						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SCHACHTER AUGUST GERALD 9:00 AM **Physician** 2004 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner #703 MONTGOMERY ROCKVILLE 6111 MONTROSE ROAD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Months Days Hours 1⊠M 2□F 93 Yrs Director 088-28-3823 0/10/1910 AUSTRIA Usual Residence of Decedent the Maryland 10c. City. Town or Location 10b. County 10d Inside City Limits 10a State Item 27 is marked other than "natural", or itams 23a or 28a-1 ehow other traumatic event, the Modical Examinar must be marified at ROCKVILLE 1X Yes 2 No MONTGOMERY Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 U.S.A. 20852 6111 MONTROSE ROAD death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 2 should be filed within 72 hours efter of and Mental Hygiene.

Is marked other than "natural", or Ital ☐Yes 2XNo Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) JEWELER JEWELRY 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be MIRIAM FUCHS MOSHE SCHACHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury as other traun 7629 FONTAINE STREET, POTOMAC, MARYLAND LINDA GORDON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) JUDEAN MEMORIAL GDNS 8/2/2004 OLNEY, MARYLAND Puneral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARÝLAND 20852 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 5 Immediate Cause (Final VL Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): anding physicien a use as the burial-Box 68760 pe Physician/Medical d attending IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month for Day 4☐Pregnant at time of death 5 Other (specify) P.O. the a detached 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending I
 A hours after death.
 Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier icai the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 AUGUST 01, 2004 out on. completed cause of de th (Item 23a) (Type, Print) Houtrose Road, ROCKVILLE, MD20852 6121 XUNOZU 5000 our 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 05

			1 - For State Registrer	State of Ma	arylan		artmen rtificat					Reg. No.			25483
	Physici	an	1. Decedent's Name (First, Middle, La Rebecca Mo11		CT.						2. Date of De Month	Day		ar	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Casey House Mont	e street and number)				Town, or	Location of		August	4c.	2004 County of D Montgo	eath	12:05 A M
	Funeral Director		5. Social Security Number 6. S			ast birthday) Yrs.	If Under Months	1 Year Days	If Under	Min.	B. Date of Bir (Month, Da	y, Year)		Birthplac Country	ce (State or Foreign fornia
	and www		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10d	I. Inside City Limits
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	sa or 28s	i Direc	10e. Street and Number 100 W. Argyle Str				10f. Zip		20850			_	zen of What ed Sta		
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id Hygiene. Id other than "naturel", or Items 23a or 28a-f show other than "naturel", or Items 23a or 28a-f show event, I've Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 5 1 If Yes, Give 1 Year or Dates:			Was Deced f Yes, spec		spanic Origin, Mexican	gin? (Spec n, Puerto R	ify Yes or No ican, etc.)	-	14. Race - A Black, W Specify:		.
Maryland 21215-0036	withln 72 hou ene. than "nature to wedleal E	Completed	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	College (1-4or 5	i+)		lent's Usua kind of wo DO NOT us ect 1	rk done d se retired)	luring mosi)	t of working	7	Ame	nd of Busine rican chiati		stry Associatio
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.O. Box 6	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pro					2	23d. Date of o	delivery Da	ly Year
S, D	ires that the de signed by the a d be detached t	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	Iting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to				cause of death?
Record	The law requires tate has been sign page 2 should be	Completed										an		o compl	r findings available etion of cause of
Vital	Physicien: Th r this certificate rral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only o	ne)			
ō	ding Phys h. After this funeral di	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui		28b. Time of Injury		Bc. Injury Work	4 🗆 Nui	28	d. Describe h	lence 6	Other (Sp.	pecify)	Hospice
_	irec	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At hor c. (Specify)	me, farm, stre	eet, factory	, office		28	f. Location (S City or Tow			Rural Ro	oute Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edicai C	29a. Certifier (Check only one) 1 X Certifying Ph 2 Medical Example (Check only one)	ysicien: To the best on niner: On the basis of and manner sta	examinati	vledge, death ion and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	d place, an	d due to the d at the time, d	cause(s)	and manner place, and d	as state	d. e cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier) _	.00.00		29c	. License	number			29d. Date	signed (Mo.	nth, Day	, Year)
7	6		1 Ag	7.	4010)		D 3!	5635			Aug	ust 3,	, 20	04
	v		30. Name and address of person tho Joseph Kaplan, M			23a) (Type, I ster N		Road	, Roc	kvill	e, MD	208	55		
	Sta Registr	-	31. Date filed (Month, Day, Year) AUG 0 4 20	32. Registra	ar's Signati		Spo								

			For State Registrar	State of	Maryland / Dep	partment of Fertificate of			iene	4 25484				
	- · · ·		Decedent's Name (First, Middle, Last	")				2. Date of Deat Month	h	3. Time of Death				
	Physici /Medic		Clara S. Scott					August	3, 2004	11:15 PM				
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, o		eath	4c. County of					
			Shady Grove Adver		SPITAI . Age (In yrs. last birthda	Rockvi If Under 1 Year	ITE	Hrs. 8. Date of Birth	Montgo	Birthplace (State or Foreign				
	Funeral Director]M 2] €F	92 Yrs.	Months Days	Hours N	Min. (Month, Day, May 29,	Year)	Vermont				
	ס		Usual Residence of Decedent		10c. City, Town or		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits				
	show	2	10a. State 10b. County Maryland Montgo	merv	Damasc					1 ☐ Yes 2 ☑ No				
	28a-f	Director	10e. Street and Number		Jamago	10f. Zip Code		11	Og. Citizen of Wha	at Country?				
	3e or		25309 Woodfield	Road		20872	2		USA					
036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Iteme 23e or 28e-1 show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	ces?	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? an, Mexican, Pu Specify:	? (Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc. Vhite				
21215-0036	ithin 72 ho ne. hen "natur Wedical	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4	4or 5+) (Gin	edent's Usual Occup re kind of work done DO NOT use retired	ness/Industry							
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	and 2 salth and 27 ls		Suellen McCarvil	l/ Daugh			ield Ro		or, City or Town, State, Zip Code) Cus, MD 20872 20c. Location - City or Town, State					
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify,			position (Name of ematory or other plan ropolitan rematory	ce)]	August 5,		ry or Town, State				
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			30. Name and address of person who d	completed cause	of death (Item 23a) (Typ	medicals	Drive	Gaithers	was MD	20810				
	Sta Registi		31. Date filed (Month, Day, Year) AUG 0 5 20		gistrar's Signature	Spark			3)					

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	Physicia		Decedent's Name (First, Middle ETHEL	die, Last)	COTT					Date of Death Month		Year)4	3. Time of Death 1:53 A M		
\geq	/Medic Examin		4a. Facility Name (If not institution		ber)		4b. City, Town, or	Location o	of Death		4c. County		1.75		
	LXamiii	٠.	NATIONAL NAVA	L MEDICAL	CENTER		BET	HESDA	A		MON	rgome	RY		
	Funeral Director		5. Social Security Number 375-40-7896		7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8	Date of Birth Month, Day, g 23,			place (State or Foreign htry) York		
			Usual Residence of Decedent				<u> </u>								
	how		10a. State 10b. Count	У	10c. Cit	ty, Town or Lo	ecation					1	Od. Inside City Limits		
	e Ma la-f s	cto	Maryland	Montgomery	Si	lver S	pring						1 Tyes 2 Tono		
	or 28	Olre	10e. Street and Number				10f. Zip Code			10	g. Citizen of V	Vhat Cour	ntry?		
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altimore, Maryland	Pages 1 annount of He annount of the		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 4 ☐ Donation 5 ☐ Other (emetery, crer lingto	sition <i>(Name of</i> natory or other place n Nationa etery		Augus 20	st 3,	oc. Location - rlingto		wn, State Virginia		
21. Signature of Toperal Service Licensee Francis J. 500 Univers													ng, MD 2090]		
			23a. Part 1. Enter the disease, of shock, or heart failure. Lis	or complications that ca st only one cause on ea	used the deat ich line.	h. Do not ent	er the mode of dying	, such as	cardiac or res	spiratory arre	st,		Approximate Interval Between		
5	Physician		Immediate Cause (Final disease or condition	7		ONARY							Onset and Death		
	/Medical		resulting in death)	Due to (or as a conseq										
	Examiner		Sequentially list conditions	b											
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a conseq	uence of):									
	nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c											
ő,	icate be executed physician and s the burial-transit	Ě	resulting in death) Last	Due to (d	or as a conseq	uence of):									
8760,	ate b hysic the b	ilca		d											
9	ertific ling p e as	Mec	IF FEMALE:	00-14											
Вох	death certificate be executed e attending physician and nd for use as the burral-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?		rth 2 🗌 Feta	I death 3	Ectopic pregnancy						Day Year		
	the a	/sic	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4∐Pregna 9☐Unkno	int at time of d wn	leath 5∟	Other (specify)					Dome Inc. Ver Spring, MD 2090 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year use contribute to the cause of death? No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No			
P.O.	that the death led by the atter detached for u	P.	Part II. Dther significant condit	tions contributing to de	ath but not res	ulting in the u	nderiving cause give	n in Part I		23a Did toba	acco use contri	ibute to th	ne cause of death?		
of Vital Records,	sigr sigr	by	Takin. Bullet significant contain			and an area	noonying oddso givo		_						
000	aw requ s been 2 shouk	Completed								24a. Was an autopsy	24b. W	ere auto	psy findings available		
æ	The lav	EO								perform 1 Yes 2	ed? d	eath?			
ta		a	25. Was case referred to medic	al				26. Place		eck only one					
\leq	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Xr	patient 2	ER/Outpatien	t 3 DOA Othe	r: 4 □ Nur	rsing Home	5 🗌 Residen	ice 6 Othe	r (Specify	1)		
0	g Physier this		27. Manner of Death	28a. Date o	f Injury n, Day Year)	28b. Time of	28c. Injury Work	at ?	28d.	Describe hov	v injury occurre	ed			
<u>o</u>	Attending F r death. ector: After by the funera	atlo	1 Natural 5 Pend 2 Accident inves	tigation (7707)	,, 50, 100,	inquity		es 2□N	No						
Division	or Attend efter death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 286 Place	of Injury - At he	ome, farm, str	eet, factory, office			Location (Stre		er or Rura	l Route Number,		
	s efter s efte	Cert		Donas	g, oto. (opco	,,				,,	-1410/				
	To the Hospitel or At within 24 hours efter d To the Funeral Direct completely filled in by	edical (ring Physician: To the al Examiner: On the ba and mann	sis of examina										
	To the k within 24 To the f complete	Me	29b. Signature and title of certifi	ier			29c. License	number		290	d. Date signed	(Month I	Day, Year)		
7			1/35	MD			01012	23515	7 (VA)	3	x 354 8	7 20	-		
0	totl		30. Name and address of perso	n who completed cause	of death (Item	n 23a) (Type,	Print)	NATTO	ONAL N	AVAT, MI	EDICAL	CENT	ER		
-			BRIAN D. SUSI		USN					D 2088		I			
	″ Sta	te	31. Date filed (Month, Day, Yea	ur) 32. Re	gistrar's Signa		1 .								
	Registr		AUG 03	2004 50	رمرب	D)	sparks								

State of Maryland / Department of Health and Mental Hygiene

			State of Me	•	Certific				leg. No	24	251,86			
		1. Decedent's Name (First, Middle, Last)					2. Dete of Dea Month	th Day	Year	3. Time of Death	3		
	Physician	Allan Spalding							4, 2004		3:40AM			
- 7	/Medical Examiner	4e Facility Neme (If not institution, give	street end number)				4b. City, Town, or	Location of Deeth						
	LXaminer	Manor Care-Bethe	sda				Bethesda		Monte	omer	v			
	Europal	5. Social Security Number 6. Se		(In yrs. last birt		nder 1 Year	If Under 24 Hrs					m		
	Funeral Director		M 2□ F	85	rs. Mont	hs Days	Hours Min.	Apr. 2	7, 1919	Kans	as			
	uth with the Maryland 23s or 28s-1 show unt be notified at rai Director	10a. Stete 10b. County		10c. City, Town	or Location	1, 2				10	•			
	S S S S S S S S S S S S S S S S S S S	Maryland Montgome	ry	Silver	Sprin	g								
	t to Sire	10e. Street end Number			10f.	Zip Code		[1	0g. Citizen of W	/hat Coun	ıry?			
	hwil 23a ai	1316 Fenwick Lane	2			20910			United	Stat	es			
	daat daat	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.			lispanic Origin? (S	specify Yes or No- to Rican, etc.)						
)20	ad within 72 hours after death with the Maryland ygiena. ••• than "natural", or items 23a or 28e-f show it, the Medical Examiner must be notified at it. Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 Yes 24 N If Yes, Give Year or Dates:	0			Specify:	,,		9. Birthplace (State or Fore Country) 9 Kansas 10d. Inside City Lim 1 Yes 2 (\$\frac{1}{2}\] 1 States 10d. American Indian, ack, White, etc. 1 States 10d. American Indian, ack, White, etc. 1 States 10d. American Indian, ack, White, etc. 1 States 10d. American Indian, ack, White, etc. 1 States 10d. American Indian, ack, White, etc. 1 States 10d. American Indian, ack, White, etc. 1 States				
ŏ	ture ed	15. Decedent's Edu	pation		16b. Kind of Bu	siness/Ind	lustry							
15	in 72	(Specify only highest grad	e completed)		(Give kind of life. DO NO	work done Tuse retire	during most of wo d)	rking	ig .					
7	withir iena.	Elementery/Secondary (0-12)	College (1-4or 5-	+1	Write	r		Free Lane						
e, Maryland 21215-0020		17. Father's Neme (First, Middle, Last)				-	18. Mother's Na	ame (First, Middle, Maiden Surneme)						
	D = 0 -	Edgar Spalding	Harrie	t Geeslir	,									
	should I ind Meni ind	19a. Informant's Name/Relationship (7)	ma Print)				State, Zip	Code) 20036	_					
	d 2 s th an 7 le s trau	Stephen W. Nealon												
	1 and Haalth am 27 ther tr	20a. Method of Disposition	ALLOTHEY	20b. Place of cemeter)				Date 41				_		
ō	2 = 2 ×	1 ☐ Burial 2 X Cremation 3 ☐ F		Montgo	mery	or other pla	сө)	Aug. 4,						
Ë	Fant: Pa	4 Donation 5 Other (Specify)			orium.	. Inc.	D	2004	Bethesda	a, Ma	ryland	- /		
Baltimore,	permit. Pages 1 Department of H Important: If Ital any Injury or ott	21. Signature of Funeral Service License Modern Mod												
		23a. Pert1. Enter the disease, or compt	ications that caused	the death. Do n	ot enter the n	node of dyi	ng, such as cardia	c or respiratory arr	est,		Approximate	_		
1	Physician /Medical Examiner	shock, or heart faiture. List only of Immediate Cause (Final disease or condition resulting in death)	Myocar	dial Ini Due to (or as a c						1 1 1 1	Onset and Death	_		
		Coronary Artery Disease												
	axecuted in end ial-transit	Sequentially list conditions, Due to (or es a consequence of):												
ó	tificate be axecuted by physician end es tha burial-transit	Sequentially list conditions, if ery, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhitted events Due to (or es a consequence of): Dementia Due to (or as e consequence of):												
68760,	flicate be a g physicial es tha bun	that initieted events resulting in death) Last												
89		Hypertension												
Вох	attending Ifor use Clan/M		d. hypertension							+		_		
	death cer e attendir ed for use sician/N	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in	the underlyin	ng cause gir	ven in Part I.	23b. Did to	bacco use con	tribute to	the cause of death	?		
0	at the death certif d by the attending etached for use e Physician/Mi							1 □ Y	es 2 No	1919 Kansas 10d. Inside City Limits 1 Yes 2 No				
O .	es that igned be be deta by P	Cerebrovascular	Accident											
Vital Records,								24a. Was a	n autopsy					
Ö		Congestive Heart	Disease					penon	ned?	cor	npletion of cause			
Re	has pe 2							1 TY	2×11					
a	ifficata tor, pe						00 Division of Div				7165 20110	_		
NE S	certificata ractor, per	25. Was case referred to medical examiner?	Hospital:			Ott	nor:	ath (Check only on						
of	Pis Pis	1 ☐ Yes 2 ☒ No 27. Menner of Death	1 LI Inpatier	nt 2□ER/Out		DUA	4 Ki Nursing r)	-		
		1 X Naturet 5 ☐ Pending	28a. Dete of Injury (Month, Day	Year) In	jury	28c. Inju Wo	rk? Yes 2⊡No		,,					
Division	Attending or death. ector: After by the funa tiffication	2 Accident investigation 3 Suicide 6 Could not be	OO - Disease of India	- Athema for		1	,100 2	28f Location /SI	reet and Numbe	er or Bura	l Route Number	-		
Ξ	or Attend after death Director: A d in by the	4 Homicide determined	28e. Place of Inju building, etc.	(Specify)	m, street, lac	iory, onice		City or Town		07 11074	Troute realition,			
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	To the Hospital of within 24 hours aff To the Funeral Discompletely filled in Medical Cel			examination end										
	within 2 To the comple	29b. Signature end titte of certifier	1/0			29c. Licens	se number	2	9d. Date signed	(Month, L	Jay, Year)			
		kents	Jok	in 1	1.0	D202	77		/	20	0.4			
	(0	30. Name end eddress of person who co	ompleted cause of de	eth (ttem 23a) (Type, Print)	D202	/4	<i>E</i>	ugust 4	20	J4	_		
	4					rd D	athoods	Manuland	20017					
		Kirti Vohra, M.D. 31. Date filed (Month, Day, Yeer)	32. Begistre	r's Signeture		-		maryrand						
F-	State	AUC 0 5 200		in /	7 19	sout.	2/							

PANCEDER ADVARCES

Funeral

Director

the Maryland 10c. City, Town or Location 10b. County 10a State Department of Health and Mental Hygiene "naturel", or items 23a or 28a-1 show important: if item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examinat must be notified at appear. Director Derwood Maryland Montgomery A KILORD 10e. Street and Number 10f. Zip Code 7244 Millcrest Terrace 20855 Funeral 12. Was Decedent Ever in U.S. Armed Forces? iled within 72 hours after 1973-1 ☐ Never Married 2X Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ Year or Dates: 1976 3 Widowed 4 Divorced and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Detective 17 Father's Name (First, Middle, Last) ストランととし Be Pages 1 and 2 should be Russell Eric Lyndon Stanford 0 19a. Informant's Name/Relationship (Type, Print) Elizabeth N. Stanford/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date August 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Scensee Letterm M01305 Immediate Cause (Final disease or condition resulting in death) Physician Advanced Pancreatic Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed Due to (or as a consequence of): physician Box 68760 Physician/Medical the as attending IF FEMALE nse s 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Completed certificate has Physician: Be 25. Was case referred to medical examiner? Hospital: 1

Inpatient 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28c. Injury at Work? Date of Injury (Month, Day Year) 28b. Time of Certification: After Hospitel or Attending 24 hours after death. 5 Pending investigation 1 X Natural М 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicida 24 hours a 29a. Certifier (Check only one) and manner stated To the Vithin 2 29c. License number

1 - State MEND#2perMD8/6/04, BMW, MbCb Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) _{Da}28 2004 **Physician** July A^{M} 5:20 Russell Eric Lyndon Stanford, II /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex 1**⋈** M 2□ F Months Days Hours 215-54-9368 September 1, 1949 Canada 54 Usual Residence of Decedent 10d. Inside City Limits 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? United States 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White Specify: 16b. Kind of Business/Industry Metropolitan Police Department 18. Mother's Name (First, Middle, Maiden Sumame) Dorothy McCrory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7244 Millcrest Terrace, Derwood, Maryland 20855 20c. Location - City or Town, State Bethesda, Maryland Robert A. Pumphrey Funeral Home / Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 6 Months 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061083 July 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive, #300, Rockville, Maryland 20850 Paul Thambi, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) south 02 2004 Registrar AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For Amend Item 23 Registrer			Cenino	ale or i	Dealii		2. Date of De		.004	25488			
	Physicia	an	Decedent's Name (First, Middle, Last)	Robert J.	Stanle	:y				Month July 2	Day	004 Year	3. Time of Death 12:43 P M			
717	/Medic Examin	_	4a. Facility Name (If not institution, give s	treet and number)		4b. 0	City, Town, or	r Location o			1	4c. County of Death				
	LXUIIII	Ċ.	Washington Adventi	st Hospit	al	T	akoma	Park		Montgomery						
	Funeral Director		5. Social Security Number 6. Sex 198–46–5113 1 №	M 2□F	(In yrs. last bin 49	thday) If U	hs Days	tf Under: Hours	Min.	8. Date of Bir (Month, Da March 2	th 19. Year) 26, 19	9. Birthpl Coun 955 Penns	lace (State or Foreign try) sylvania			
	DG 💌		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside Cit					
	lanyla sho	ö			,,								1⊠Yes 2□No			
	28a-	Director	Maryland Montgomen	- У			nestow . Zip Code	/11			10g. Citi	zen of What Coun	try?			
	3a or		16131 Riffle Ford	Road			20	0878			Uni	ted Stat	es			
	be filed within 72 hours after death with the Maryland tial Hygiene. all Hygiene. do other than "natural", or items 23a or 28a-f show svent, I're Medical Evaniner must be indiffed at	Funerai	11. Maritaf Status	2. Was Decedent E	ver in U.S.	13. Was D	ecedent of H	ispanic Original	gin? (Spec	offy Yes or No Rican, etc.)		14. Race - Americ Black, White,	an Indian,			
020		by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			s 2 No		, 1 461(0 1	noari, etc.,		Specify: Whi				
ָר ה	72 hc	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's (Give kind o	work done	during most	t of workin	g	16b. Ki	nd of Business/Inc	dustry			
Maryiand 21215-0036	within iene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		`life. DO NO	T use retired	1)				None				
N ·	filed v Hygie other t								r's Name	(First, Middle	, Maiden					
	od be to see to	o Be														
2	should be and Mental is marked of sumatic sv	유									nestown, Maryland 20878 20c. Location - City or Town, State					
Σ	9 E P E		Andrew J. Stanley,	Sr./Fathe	er 16	131 Ri	ffle F	ord Ro	ad,	Darnes	town	, Marylan	nd 20878			
<u>5</u>	s 1 and 3 if Health Item 27 other tr		20a. Method of Disposition		20b. Place of	Disposition	Name of		Da							
Ē	Pages John of International		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Gate	y, crematory of Hea meterv	ven	A LA	ugus 200	t 2,	Silv	er Spring	, Maryland			
Baitimore,	permit. Pages 1 an Department of Heali Important: If Item 2 any injury or other once.	21. Signature of Funerat Service Licensee 22. Name and Address of Facility Robert A. Pumphre 300 West Montgomery														
			23a. Part1. Enter the disease, or complications, or heart failure. List only on timmediate Cause (Finat	rract	110,110	Approximate fntervaf Between Onset and Death										
F	Physician /Medical		fmmediate Cause (Finat disease or condition resulting in death)	Tabri	ation	1 Heumo	nia			•		-	l day			
	Examiner			Due to (or as a	consequence	01):					1					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a	consequence	of):					11	D BY MEDICAL EXAMINER				
'n	tte be executed ysician and he burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a	consequence	of):				ATION APP	ROVEDBY	MEDICAL EXAM				
	ate be nysici he bu	icai							CERT							
200	artifica ing ph a as t	Med	IF FEMALE:							/						
F.O. BOX	The law requires that the death certificate attending phy the attending phy page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1								2	23d. Date of delive Month	ry Day Year			
૧	res that igned b	by	Part II. Dther significant conditions con Autism	tributing to death but	not resulting in	n the underlyi	ng cause giv	en in Part I.		1	obacco u Yes 21	se contribute to th	e cause of death?			
01.0	v requir been si should I	eted										Towns and the				
		Completed	Severe Mental Reta	ardation		-			_	24a. Was auto perfo	osy ormed?	24b. Were autor prior to con death? 1 \(\text{Yes}	osy findings available inpletion of cause of			
<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?				0#			(Check only o						
	Physician: this certific	၉	IN 182 ZENO		t 2 ER/Ou					e 5 ☐ Resi 8d. De <i>s</i> cribe		6 ☐Other (Specify)			
		lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day July 28,	Yeer) 200. I	Time of njury	28c. injur					ked on fo	hood			
2	l or Attanding after death. Director: Afte I in by the fune	Icat	2 X Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Pface of Injur				.03 2 1								
=	i ji fe	Certification:	4 ☐ Homicide determined	group ho	(Specify)	,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or Too delphi		3015 Si.	lver Lake (
	To the Hospitel or Attenwithin 24 hours after deal To the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1	ician: To the best of	my knowledge				d place, a	nd due to the	cause(s)					
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens	e number			29d. Dat	e signed (Month, L	Dey, Year)			
ı	1		1 open Dage	201 -			D5	2381			Ju1	y 31, 20	04			
	1		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)					 ,					
			Robyn Anderson, M.		Carrol1		ie, Ta	koma	Park,	Mary]	Land	20912				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** August 2, Sweet 8:27 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 17532 Shenandoah Court Ashton Montgomery 8. Date of Birth (Month, Day, Year) May 31, 19 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 **№** M 2 🗆 F 66 078-30-4245 1938 Director Connecticut Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28e-f show treumatic event, the Medical Examiner nest be notified at 1 ☐ Yes 2 → No Maryland Montgomery Ashton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA or Items 23a 17532 Shenandoah Court 20861 e filed within 72 hours after death is Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give 1968-71 Year or Dates Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify.White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deputment of Health and Mental Hy Important: If teem 27 is marked oth any injury or other treumatic event gotes. Be George B. Sweet May Miller 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Sweet/ Wife 17532 Shenandoah Court, Ashton, MD 20861 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven 20c. Location - City or Town, State 20a Method of Disposition August 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) 2004 Silver Spring, MD Cemetery 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 Years disease or condition resulting in death) Cardiomyopathy- Ischemic /Medical Due to (or as a consequence of): Examiner 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events Diabetes Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and I for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 Yes 2 🗔 No Division of Vital Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🙀 Residence 6 ☐ Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After or Attending Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide To the Hospitel o within 24 hours aft To the Funerel Di 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0+1 D21340 August 5, 2004 30. Name and address of on who completed cause of death (Item 23a) (Type, Print) Bass, M.D. 3941 Ferrara Drive, Wheaton, MD 20902 Raymond A. 31. Date filed (Month, Day, 32. Registrar's Signature State AUG 0 6 2004

Registrar

			1 - For State Registrar	State of Mary	•	artment of F rtificate of		nd Me		iene •g. No. () ()	eman, cl	25490			
	Physici	an	1. Decedent's Name (First, Middle, Last) Joan E. Twifor	đ					2. Date of Deat Month	Day	Year	3. Time of Death 11:40 P M			
1	/Medio		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of		August	-	4c. County of Death				
			Montgomery Hospi			Rockv					tgome				
П	Funeral Director		5. Social Security Number 6. Sex 1 1	14 of the	n yrs. last birthday) 53 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min	B. Date of Birth (Month, Day, Feb. 9,	Year)	Cour	place (State or Foreign htry) nington, DC			
	ס		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	neation						0d. Inside City Limits			
	Manyla f shov	or	Maryland Montgo:		-	ry Villa	ge					1 ☐ Yes 2 ☑ No			
	n the h	Director	10e. Street and Number			10f. Zip Code			10	0g. Citizen of \	What Cour	ntry?			
	23a o		9491 Chadburn Pl	ace		20886					USA 14. Race - American Indian,				
36	s within 72 hours after death with the Maryland liene. r than "natural", or items 23a or 28a-1 show the Mccircal Exeminer must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	dispanic Orig an, Mexican, Specify:	in? (Speci , Puerto Ri	ify Yes or No- ican, etc.)	Blac	e - Americ ck, White, y: Whi t	etc.						
21215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NDT use retire	during most	of working	7	16b. Kind of Bi	usiness/In	dustry			
	a filed w Il Hygier other th										Communications aiden Surname)				
land	should be fund Mental I	17. Father's Name (First, Middle, Last) John C. Twiford 18. Mother's Name (First, Middle, Maiden Su													
Maryland	2 shou and M is mar sumat	-	19a. Informant's Name/Relationship (Typ	ов, Print)	19b. Maili	ng Address (Street	and Number	r or Rural i	Route Number,	City or Town,	State, Zip	Code)			
Baltimore, M	l and the lealth im 27 her tr		Michelle L. Green 20a. Method of Disposition 1 (A Donation 5 Other (Specify)	2	20b. Place of Dispo cemetery, crei Gate C	sition (Name of matory or other pla DE Heaven		Da	ust 4	20c. Location -	City or To				
Baltii	permit. Pages 1 Department of H Important: If Ite any injury or of once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 209												
	Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or compile shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Metastat: Due to (or as a co	ic Cancer					est,		Approximate Interval Between Onset and Death			
,820,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	==									
O. Box 6	that the death certific hed by the attending p i detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у			1	te of delive	ery Day Year			
rds, P	sign Sign d be	by	Part II. Other significant conditions con	contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tob			ne cause of death?			
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Vita	S S S	o Be	25. Was case referred to medical examiner?	ospital:	27.58/0	Ott			Check only one		(0				
of	Attending Physic death. sector: After this by the funeral di	}	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier 28b. Time o lnjury	f 28c. Inju	ry at	28	e 5 Heside 8d. Describe ho			Hospice Facility			
Division	E Dist	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, sti Specify)	reet, factory, office		28	3f. Location (Str. City or Town		er or Rura	l Route Number,			
	5 4 3 9	edical		sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or in										
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	All C		29c. Licens	se number	12	29	9d. Date signed	d (Month.	Day, Year)			
	\		30. Name and address of person who co Charles Harrison,	M.D. 6001	Muncaste		oad, R	Rockv	ille, M	D 2085	5				
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 3 200	32. Registrar's	10	Soort									

DHMH 17 Rev 1/2001

Registrar

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AUG

JAMES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

4b. City, Town, or Location of Death

200U

4c. County of Death

2. Date o

ALLUST

Reg. No.	2549
f Death	3. Time of Dea

450 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Physician
/Medical
Examiner

Funeral Director

august 2, 2004 Box 68760. Records, P.O. bo C warner, James

Suburban Hospital Montgomery Bethesda If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Aug. 19, 1 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 1**X** M 2□ F Min. Hours 524-58-2166 56 1947 Colorado Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Examination at the notified at Directo Maryland Montgomery Potomac 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9909 Avenel Farm Drive 20854 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Inportant: If item 27 is marked other then "naturel", or iten any injury or other treumatic event, the Medical Exambra. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Senior Solutions Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James S. Warner Rose Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9909 Avenel Farm Drive, Potomac, Maryland 20854 Yvonne Chen/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 5, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/0 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 * 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Why Concer Physician METHYLATIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-tran the attending physician and Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Ves 2 No 9 Unknown by been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed certificate has been 24a. Was an autopsy performed? page 2 Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ō the Hospitel within 24 hours a 29a. Certifie 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certif 29c. License number 1729675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4100 BETHESDA, MD LANGH BOCUS 6420 Rock-LODGE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

MARNER

4a. Facility Name (If not institution, give street and number)

United States 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Hewlett Packard 20c. Location - City or Town, State Approximate Interval Betweer Onset and Deatl Hylpen o 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

State

Registrar

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			1 - For State Registrar		aryland / Depa		Health and M	lental Hyg	_	25493			
	-:-		1. Decedent's Neme (First, Middle, Last))				2. Date of Dear Month		3. Time of Death			
15	Physici /Medic		Virginia A.	Watso	n			July 31	, 2004 Yeer	3:45 A ^M			
	Examir		4e. Fecility Name (If not institution, give				or Location of Death		4c. County of Dea	th			
			Woodside Nursing	& Rehab C	enter	Silver	Spring		Montgomery				
h	Funeral Director		379-30-0014	7. Age 7. Age 96	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Jan . 29	9. Bir 1908 Wave	thplece (State or Foreign bunity) CTLY, VA			
	e Maryland 3a-f ehow	ctor	Usuel Residence of Decedent 10a. State 10b. County Montgome:				10d. Inside City Limits						
	th with the 23e or 21	Funeral Director	10e. Street and Number 8201 16th Street			10f. Zip Code 20910	0		ountry? es				
036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ha Madical Examiner cust by multified at	by	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ♣ N If Yes, Give Year or Dates:	10	Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	14. Race - Ame Black, Whit Specify: B1	e, etc.				
Maryland 21215-0036	within 72 ho iene. • than "natur ihe Maulcal	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(Give		pation during most of work ad)	ing	16b. Kind of Business D.C. Publi Schools	,			
Ö	Hyg other		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, I	Maiden Sumame)				
<u>a</u>	id be ental ked o	To Be	Gurney Columbus A	Anderson									
lary	2 shou and M ie mar	-	19a. Informant's Name/Relationship (Ty	rpe, Print)					City or Town, State,	Zip Code)			
≥,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Any injury or other traumatic event, the Maulical Examiner must be nutified at any injury or other traumatic event, the Maulical Examiner must be nutified at any injury or other traumatic event, the Maulical Examiner must be nutified at		Florence S. Boone	-Niece			N.W. Wash						
More			20a. Method of Disposition 1 **Burial 2 Cremation 3 Removal from State 1 **Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Et. Lincoln Cemetery 8/6/04 **Brentwo										
Baltimore,	Departm Departm Importar any injui		*4 Donation 5 Other (Specify) 21. Signatury of Funeral Service Unit (Specify) 22. Name and Address of Facility McGuire Funeral Service (7400 Georgia Ave., N.W. Wash., D.C.										
	A S		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Finat	ications that caused ne cause on each lin	the death. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory erre	est,	Approximate Interval Between Onset and Death			
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	Respirato:		ess Syndro	ome		Immediate			
	- Xaiiiiilei	10	Sequentially list conditions,	4.	tatic Lung	Disease		_		3 years			
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oʻ	ie be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last		J years								
68760,	physic the bu	dicai		-									
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be delached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②☑No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	ivery Day Year			
2	uires that signed by Id be deta	by	Part II. Other significant conditions cor	ntributing to death bu	ut not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
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<u> </u>	: The law cate has l	Con						perform 1 ☐ Yes 2		2 No			
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0	this ald	T _o	1 Yes 2 No	1 🗆 Inpatie		IL 3 DOA			nce 6 Other (Spe	cify)			
Division of	ending f sath. or: After he funer	ation	1 Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	Yeer) 28b. Time of Injury	Wo	ryat rk?]Yes 2 □No	28d. Describe no	w injury occurred				
Ω	s after d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	aral Route Number,			
	To the Hospitel or Attending Physicien: Within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director,	Medical (29a. Certifier	sicien: To the best of ner: On the basis of and manner sta	of my knowledge, death examination and/or in- ited.	h occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)			
	To th To th comp	ž	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Mont	h, Day, Year)			
•	4		> Elew any			MD 2	5586		08/03	WY			
	·		30. Name and address of person who con Edward D. Belton	, M.D. 16	eath (Item 23a) (Type, 529 Columbi	Print) La Road.,	N.W.#334	Washir	gton, D.C.	20009			
	Sta		31. Date filed (Month, Day, Year)		ar's Signature	South.	/						

DHMH 17 Rev 1/2001

Registrar

2004

			1 = For State Registrar	State of Marylan	-	artment of H			giene Reg. No. 0 ()	4 25495		
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				2. Date of De. Month		3. Time of Death Year		
	Physicia /Medic	al	Agnes Madeline Wh						4, 2004	12:05am ^M		
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or		eath	4c. County o			
			1104 Lewis Avenue 5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	Rockvil If Under 1 Year			Montgomery of Birth h, Day, Year) 9. Birthplace (State or Foreign Country)			
	Funeral Director		o. occurry trains	□M 2\\ F 83		Months Days	Hours M	Jan. 22	y, <i>Year)</i> 2, 1921 N	Country) Maryland		
	D		Usual Residence of Decedent	100 6	ty, Town or Lo	anting.				10d. Inside City Limits		
	arylar show	7	10a. State 10b. County			Cation				1 ⊠Yes 2 □ No		
	the M	Directo	Maryland Montgome	ry Roc	kville	10f. Zip Code			10g. Citizen of W	/hat Country?		
	with Be or		1104 Lewis Avenue			20851			United S	,		
	death ms 2%	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.		ispanic Origin?	? (Specify Yes or No	- 14. Race	e - American Indian, k, White, etc.		
9	after or Ite		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 21X No If Yes, Give		1 ☐ Yes 2 ဩX No	Specify:	dorto riloari, oto.,	Specify:			
003	should be filed within 72 hours after death with the Maryland of Mental Hygene. marked other then "neturel" or Items 23e or 28e-f show marked other then "neturel" or Items 23e or 28e-f show maric event, the Medical Examinar must be notified at	d by	3∑ Widowed 4 □ Divorced	Year or Dates:	16a Doog	dent's Usual Occup	ation		16b. Kind of Bu	wnite		
<u>-</u>	n 72 in 72 in 1900 in	Completed	15. Decedent's Edu (Specify only highest grad	de completed)	(Give	kind of work done of DO NOT use retired	during most of	working	10b. Killa of bus	sitessitiousity		
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_	_ 0 9	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame	9)		
<u>Jar</u>	should be nd Mental marked o	ToE	James Harry Fenha	gen				Eva Goddar				
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 le marked eny injury or other treumatic engo.		19a. Informant's Name/Relationship (T		1	_		r Rural Route Numbe		20000		
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Baltimore,	No = 10		1 X Burial 2 ☐ Cremation 3 ☐			esition (Name of matory or other place		0.10.10.4		·		
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Ba	Depure limpo		VI-HALL	1111	G.	O East De aithersub	er Parl	k Drive 20877				
			23a. Part1. Enter the disease, or comp	lications that caused the dea	th. Do not en	er the mode of dyir	ng, such as car	diac or respiratory a	rrest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	Arterioscler	otic C	ardiovasc	ular D	isease		Onset and Death		
	/Medical		resulting in death)	Due to (or as a consec	quence of):							
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о. П	0 0 0	/sici	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐ Unknown	death 5[Other (specify) _						
<u>α</u>	hat the	Phy	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use contri	ibute to the cause of death?		
ds,	signe signe		•					1 🗆	Yes 2 XNo	3 ☐ Probably 4 ☐ Unknown		
Record	w requir been si should	Completed						24a. Was		Vere autopsy findings available		
Re	The lav	ошо						— autoj perfo 1 Yes	rmed? d	rior to completion of cause of leath? Yes 2 No		
Vital		Φ	25. Was case referred to medical				26. Place of	Death (Check only o				
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n of	fter fter		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe	how injury occurre	ed		
sio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	-	nome form et		Yes 2 □ No	28f Location /	Street and Number	er or Rural Route Number,		
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	o the o the o the omple	₩	29b. Signature and title of certifier	•		29c. Licens	se number		29d. Date signed	i (Month, Day, Year)		
	20		Draul.o	Weekling M	D	D 1	.9785		August 4	4, 2004		
	V		30. Name and address of person who			Print)	100	5 2 3				
_			Frauke Westphal,					Rockville	MD 208	54		
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 0 5 2	32. Registrar's Sign	nature 5	Spark						

			1 - For State Registrar	State of	Marylan		artmen <i>rtificate</i>				ental Hy	gien Reg. N	2001	251	96
	Dhusia		1. Decedent's Name (First, Middle, L	ast)							2. Date of De				of Death
3	Physic /Medi		Herman		Weiner	r					August	t 1,	2004 Yeer		5 P M
	Exami		4a. Facility Name (If not institution, go	ve street and numb	oer)		4b. City, Town, or Location of Death					4	4c. County of Deeth		
			Montgomery Gener				01ney						Montgomery		
	Funeral			Sex 7. 1	Age (In yrs.		Months Days Hours Min (Month Day Yo						9. Birthplace (State or Foreign		
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	land		10a. State 10b. County		10c. City	y, Town or Lo	ocation							10d. Inside	City Limits
	the Marylar 28a-f show	ō	Maryland Montgo	merv	Roc	kvill									s 2 No
	289	Director	10e. Street and Number		THE C		10f. Zip	Code				10a C	itizen of What C	4.8	
	th with 23a or	Ö	4405 Cherry Vall	ev Drive				2085	53			-	ited St		
	ier deeth with the Maryland Items 23e or 28e-1 show instituted by items of the contract of the	by Funeral	11. Marital Status	12. Was Decede	ent Ever in U.	S. 13.	Was Deced			gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Am		
9	after or Ite	Fu	1 Never Married 2 Married	Armed Force	□ No.					, Puerto P	Rican, etc.)		Black, Wh	ite, etc.	
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ō,	Heal Heal tem 2		20a. Method of Disposition	MTT C:	20b. PI	lace of Dispo	sition (Nam	e of			ite		ocation - City or		
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	1.77		23a. Part1. Enter the disease, or con	plications that cau	sed the death	n. Do not ent	er the mode	of dvino	such as o	Pike,	respiratory ar	rest	e, MD	20852 Approxima	ate
ń.	Physician /Medical Examiner	resulting in dealh) Due to (or as a consequence of):											Interval Be Onset and		
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٦,	uires that signed b	by PI	Part II. Other significant conditions	contributing to death	n but not resu	Iting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	bacco	use contribute to	he cause of	death?
ğ	quire in sig uld b										1 🗆 Y	es 2	No 3□P	obably 4 🗆]Unknown
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of	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Ir		28b. Time of		c. Injury			d. Describe h			city)	
0	uttendin death. ctor: Afl y the fur	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio		Day (Gal)	Injury	м		, es 2 □ N	0					
Division	after Dirs	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At honetc. (Specify)	me, farm, stre	et, factory.	office		28	f. Location (S City or Tow	treet ar	nd Number or Ru e)	ıral Route Nun	nber,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 ☐ Cartifying PI (Check only one) 2 ☐ Medical Exam	nysician: To the be minar: On the basis and mathner	or examination	vledge, death on and/or inv	occurred at estigation, i	t the time	, date and nion, death	place, an occurred	d due to the o	ause(s late and) and manner as d place, and due	stated. to the cause(s	s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	///			29c.	License	number				te signed (Monti		
Z. 1	7		1 Colliss	1			0	05	386	4	/	109	UST Z	, 700	34
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	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	strar's Signatu	ure 19	Spar	KN	′						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 01:47 AM **Physician** Weiner Hugust 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death **Examiner** 0 IMORE Ma If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year 5. Social Security Number & Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Yrs 427-96-7599 JUNE 1958 MISSISSIPPI 46 Director 6, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event; the Madical Examinat must be notified at aprica. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Funeral Director MARYLAND MONTGOMERY **BETHESDA** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7103 FAIRFAX ROAD 20814 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: ģ WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PRIVATE AND Elementary/Secondary (0-12) College (1-4or 5+) 5+ PUBLIC SCHOOLS SCHOOL TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LEAH ISRAELSON CHARLES AZARCH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 FAIRFAX RD., BETHESDA, MD 20814 LEE M. WEINER/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) GARDEN OF REMEMBRANCE 08/06/2004 CLARKSBURG, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Donald 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** cute /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 1 Yes 2010 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To 2 ER/Outpatient 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the t Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (medical Doctor RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damian Chaupin MD, Johns Hopkins Hospital, Tower NO, 600 North Wolfe Street, Baltomore, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 AUG 0 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 51,98 Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Louis A. Wienckowski August 2, 2004 A^{M} 6:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 102) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** 1⊠M 2□F 83 18, Director 050-12-7027 1921 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or iteme 23a or 28a-f show an injuly open the treumetic event, the Medical Exactine must be notified at once. 10a. State 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Montgomery Rockville Funeral Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5911 Holland Road 20851 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 【 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 ₩ Widowed 4 Divorced WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Administrator Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Zygumd Wienckowski Stella Gramza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2118 Chantilla Road, Baltimore, Maryland 21228 Peter A. Wienckowski/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State August 6, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park Rockville, Maryland 4 □ Donation 5 □ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee M00198 0 23a. Part 1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 6 days Priysician Methicillin Resistant Staphylococcus Aureus resulting in death) /Medical **Examiner** 6 days Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed the attending physician and thed for use as the burial-transit Acute Renal Failure 4 days Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2☑ No Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu death. investigation М 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) August 2, 2004 1241 6/8/ nd address of person who completed cause of death (Item 23a) (Type, Print) Shahyar M. Gharacholou, M.D. 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 05 Registrar